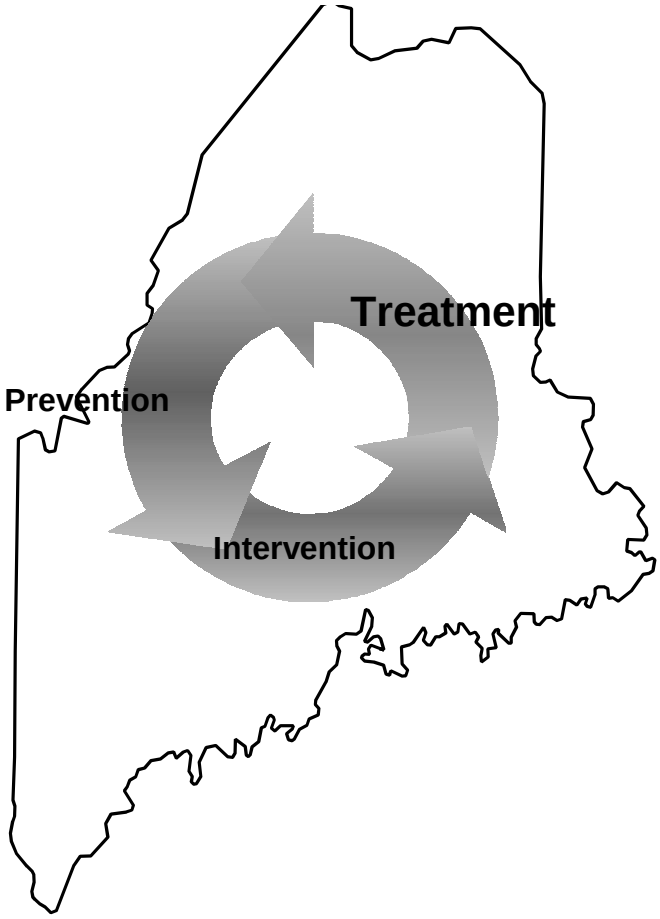
State of Maine
Substance Abuse Treatment Needs Assessment



Study 5: Assessment of Maine's Substance Abuse Treatment System: Structure, Capacity, and Utilization

Maine Office of Substance Abuse
Department of Mental Health, Mental Retardation, and Substance Abuse Services
July 1999

CSAT
Center for Substance Abuse Treatment
SAMHSA

State of Maine
Substance Abuse Treatment Needs Assessment

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FINAL
REPORT

Prepared in Collaboration with
the
Maine Office of Substance Abuse

by

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Maine Office of Substance Abuse
Department of Mental Health, Mental Retardation, and Substance Abuse Services

July 1999

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Executive Summary

Prepared by

Maine Office of Substance Abuse
DMHMRSAS
and
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This report was prepared by Maine's Office of Substance Abuse (OSA) and Research Triangle Institute (RTI) as part of a 3-year project titled, "Maine State Demand and Needs Assessment Studies: Alcohol and Other Drugs" (Center for Substance Abuse Treatment [CSAT] Contract No. 270-95-0030). This report includes findings from the fifth in a series of six studies of the need and demand for, and availability of, substance abuse treatment services in the State of Maine. The purpose of this report is to assist the state in its efforts to determine the capacity of the formal treatment system and its ability to meet current demand for services.

This report is based on analyses obtained from multiple data sources, including a survey of all state-recognized formal treatment organizations in Maine, as well as secondary data from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Uniform Facility Data Set (UFDS) and Treatment Episode Data Set (TEDS). The primary goal of this study was to estimate the patient capacity of formal substance abuse treatment programs operating statewide. Capacity was estimated using two approaches. Static capacity estimates reflect the number of clients who could be treated on any given day; these figures reflect a point-prevalence or "snapshot" approach. Dynamic capacity estimates reflect the number of patients who could be treated across all of the state's programs over the course of an entire year; these estimates account for variations in patient length of stay and patient-to-counselor ratios. Utilization figures also were obtained; these include average daily census (a point-prevalence measure), total annual admissions (duplicated patient count), and average length of stay. Information from the UFDS as well as from the TEDS public use data file provides an overview of the characteristics of patients admitted to the treatment system over the course of a recent and representative year.

Highlights of this report include the following:

- Of the 135 responding organizations (a combined 152 service delivery units), 21 offer detoxification services, 28 offer residential rehabilitation services, 14 offer intensive outpatient care, and 121 offer nonintensive outpatient treatment services.

- Maine's treatment providers report that they can accommodate about 7,500 patients in outpatient services on any given day; about 450 beds are available for inpatient or residential rehabilitation or detoxification services.

- Maine's treatment providers reported treating approximately 7,780 patients on any given day during the reference year (October 1, 1996, to September 30, 1997). As noted above, the vast majority (about 7,500) of these patients (96%) were receiving outpatient services.

- On an annual basis, and based on the average length of stay reported by providers, Maine's state-licensed system is estimated to be able to treat about 40,600 admissions to treatment. Most of this capacity (about 71%) is for outpatient services.

- Admissions for the reference year (October 1, 1996, to September 30, 1997) were estimated at 44,935. The Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) Region I accounted for about 9,800 of these admissions, with Region II accounting for approximately 25,000, and Region III accounting for 10,000.

- Overall, the system is operating at near capacity (98%) on an average day and above capacity (110%) on an annual basis.

- On the basis of annual admissions, the system is estimated to be able to meet about 55% of the statewide need for substance abuse treatment.

- Individuals admitted to treatment tend to be male (75%), between the ages of 25 and 44 (63%), never married (47%), not in the labor force (48%), and having at least 12 years of education (65%). The majority of patients (66%) have accessed the treatment system on at least one prior occasion; most patients admitted to detoxification have received treatment previously (86%).

- Individuals admitted for treatment in Maine tend to be polydrug abusers; more than 49% of admissions required treatment for both alcohol and other drug problems. Among substances used, alcohol was the most common, followed by marijuana and cocaine.

- The vast majority of responding programs (86%) noted that managed care creates barriers to treatment. One third of programs reported that managed care gatekeepers did not approve adequate treatment regimens, and fully 75% of programs said that patients under managed care did not have access to sufficient wraparound services to ensure optimal treatment outcomes.

Overall Summary

This study provides an important beginning to understanding the structure and capacity of Maine's state-approved substance abuse services system. As additional research is conducted by OSA and as additional administrative data are developed from the Office of Substance Abuse Data System (OASD) and other sources, it will be possible to improve the accuracy of specific data elements and to add details on service elements offered within various regions and by specific providers and on issues related to the performance of providers. Nonetheless, there are at least four important issues that OSA can begin addressing now based on the current information:

(1) Based on the estimates of overall need developed by the Maine State Needs Assessment Project and the data on system services available, are overall treatment services available to accommodate the current demand for services?

(2) It is clear that the gap between the number of Maine citizens in need of treatment and the number who demand and/or perceive they need treatment is large. Therefore, at issue is whether the state should consider special efforts and programs to more broadly address the issue of alcohol and/or drug dependency and/or abuse within regions and statewide and whether the additional resources that would be needed to meet the demand resulting from these special efforts are available.

(3) A third issue concerns whether the appropriate types of services are most effectively allocated currently across regions and the state. How will additional services—if any—be allocated?

(4) And finally, OSA staff and others concerned with providing substance abuse treatment services in the state can use this document to develop information to help guide efforts to provide a continually more effective and efficient substance abuse treatment services system.

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1. INTRODUCTION

This report presents findings about the structure, capacity, and utilization of substance abuse treatment programs currently operating in the State of Maine. It includes information on the services offered by the state-approved formal treatment programs currently operating in the state, as well as estimates of treatment capacity and utilization and the characteristics of individuals accessing the treatment system. Importantly, this study permits a broad assessment of the disparities between the supply and demand for treatment in the state. This study is part of Maine's substance abuse treatment needs assessment project, conducted by the Maine Office of Substance Abuse (OSA) and Research Triangle Institute (RTI).

This report is divided into four chapters. In this chapter, we present an overview of the purpose and contribution of this study. Chapter 2 describes the sources of data for this study, including treatment programs providing information about their services, as well as secondary sources of data used in our analyses. Chapter 3 presents statistical estimates of the static (point-prevalence) and dynamic (annual) capacity of the treatment system, as well as information about recent utilization of the treatment system; this information is used to address the adequacy of supply, given current demand and need for treatment statewide. Limited additional information is provided on program structure, patient retention, and the influence of managed care on service delivery. Finally, Chapter 4 provides conclusions and recommendations for state decisionmakers.

1.1 Overview of Maine's Demand and Needs Assessment Studies

The Maine demand and needs assessment family of studies is designed to provide a valid and reliable database of information to facilitate short- and long-term planning and to aid in implementing services to meet population needs effectively and efficiently. The specific objectives of the project are to

- develop statewide, substate, and county-level estimates of the need for treatment for problems related to the abuse of alcohol and other drugs for the total population and for key subgroups;
- determine the extent to which these needs are being met by the current treatment system;
- develop low-cost, valid methodologies that can be used by the state in subsequent years to estimate treatment needs; and

- identify key gaps in Maine's current data collection efforts relating to needs assessment.

The demand and needs assessment project consists of six studies designed to achieve these goals. These studies were selected to achieve broad coverage of the state's population, to provide reliable information on met and unmet treatment needs, and to develop tools that can be used by the state in the future for estimation and planning purposes. The project includes a range of methodologies, including telephone interviewing, computer-assisted personal interviewing (CAPI), record abstraction, analytic modeling, and integrative analyses, which together provide a comprehensive base of information that Maine can use to continue to improve its efforts to meet the alcohol and drug abuse treatment needs of its population. The six studies are as follows:

- Study 1: Alcohol and Other Drug Household Estimates;
- Study 2: Use of Alcohol and Illicit Drugs and Need for Treatment Among Maine Adult Arrestees;
- Study 3: Estimating Need for Treatment or Intervention Among Youth in Maine Counties: A Synthetic Estimation Approach;
- Study 4: Using Social Indicators to Estimate Substance Use and Treatment Needs in Maine;
- Study 5: Assessment of Maine's Substance Abuse Treatment System: Structure, Capacity, and Utilization, 1997; and
- Study 6: Integrated Population Estimates of Substance Abuse Treatment and Intervention Needs in the State of Maine.

Independently and together, these studies offer an important knowledge base for Maine to continue to improve its efforts to meet treatment needs and to allocate resources.

1.2 Assessment of the Current Treatment System

To ensure that substance abuse treatment services are provided to those in need of treatment, OSA needs information not only on those in need of treatment but also on the availability and utilization of treatment services statewide. Emerging issues such as managed care also have profound effects on treatment providers and the treatment system. This study is viewed as a key component of Maine's demand and needs assessment project and is vital to OSA's planning and management functions.

The objectives of Study 5 included the following:

- Describing the structure and operation of the current treatment system. Specific goals associated with this objective included collection of information on the number, location, and organizational characteristics of the state's treatment providers, services offered, utilization of services, and characteristics of clients accessing services.

- Determining the current capacity of the treatment system to deliver needed services and estimating the "treatment gap" (the level of unmet need or excess capacity) both regionally and statewide.

- Developing information to begin to assess the current status and potential future impact of managed care on the availability, delivery, and effectiveness of the Maine treatment system.

- Identifying issues requiring additional research and analysis.

The primary objective of the treatment system study was to gather data with which to assess the adequacy of the formal treatment system for meeting the substance abuse treatment needs of the people of Maine. This objective was met through the analysis of data obtained from multiple sources, including a survey of the state's providers, as well as data collected for the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Drug Abuse Services Information System (DASIS). The information collected through this study, when compared to treatment needs identified through other studies in Maine's needs assessment project, will be useful in determining the adequacy of the existing system and the need for additional services, treatment slots, and facilities for the substance-abusing population in the State of Maine. Additionally, this information can be used to identify the strengths and weaknesses of the existing treatment system.

Analyses of data from the National Household Survey on Drug Abuse (NHSDA) and other sources indicate a significant gap between the number of persons in need of substance abuse treatment and the number actually receiving treatment services nationwide. Overall, SAMHSA estimates that only about half of all substance abusers receive the treatment they need (Woodward et al., 1997). Although the treatment gap has declined in recent years (i.e., a larger proportion of the population in need is being served), there are still significant shortfalls in the provision of treatment services to individuals dependent on alcohol and other drugs. In addition, the size of the treatment gap varies by service sector; many publicly funded treatment programs are filled to capacity and maintain waiting lists, while many private-sector programs

have excess capacity. From a public policy perspective, it is essential for states not only to measure the extent of the need for treatment but also the availability of treatment services; public dollars must be allocated to providers serving those regions or populations with the greatest degree of need.

Defining the availability of treatment services requires more than simply counting the number of treatment slots and admissions. Because addiction is a disease of relapse, substance abuse treatment is a dynamic process that results in the movement of many of the same people in and out of the treatment system or across different treatment programs. As part of a single treatment episode, an individual might use services from more than one program. Likewise, because substance abuse is often a chronic condition, repeated admissions to treatment represent characteristic patterns for many clients. Given the cyclical nature of treatment, it is imperative not only to count the number of admissions to treatment services but also to track the flow of clients throughout their treatment process.

Determining the types of services clients require is another dimension of the dynamic process of substance abuse treatment. Clients using the system differ greatly in the type and intensity of services needed. The services required will vary from client to client and may vary each time a client re-enters the treatment system. For instance, one individual may require both detoxification and residential services in their initial treatment episode but only outpatient treatment if they are re-admitted after experiencing a relapse.

Most of the available estimates of treatment capacity and utilization rely on incomplete data sources, use point-prevalence data exclusively, or do not permit state-by-state comparisons. Also, many estimates refer only to the bed capacity of treatment providers; however, recent trends toward outpatient treatment as the predominant treatment modality have rendered estimates based on bed capacity increasingly unreliable. In Study 5, we sought to collect data from the census of Maine's state-funded treatment providers, including data suitable for estimating annual capacity and utilization rates. These findings can be compared with data on the need for treatment obtained from the 1997 Maine household survey, conducted under Study 1 of the Maine needs assessment project.

1.3 Review of Findings from the 1997 Household Survey

The study of the current treatment system provides an important complement to the other studies conducted under this needs assessment project. In particular, it provides information on the supply side of the treatment equation. Each of the companion studies listed earlier has contributed information on the need for treatment among various segments of Maine's population. The 1997 Maine household telephone survey provided statewide estimates of the need for treatment as well as the met and unmet demand for treatment among the household population. Because this study focuses on the formal treatment system and programs available to the general public, this report allows further analysis of the degree to which state-funded providers are able to accommodate the number of individuals requiring substance abuse treatment.

1.3.1 Need for Treatment

Table 1 shows data compiled for the 1997 Maine household telephone survey under this needs assessment project. This table provides percentages as well as estimated numbers of individuals statewide who were in need of substance abuse treatment or intervention services in 1997. The definition of need for treatment approximates the criteria for substance abuse or dependence specified in the third, revised edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)* (American Psychiatric Association [APA], 1987). A full discussion may be found in the final report for Study 1 by Kroutil and colleagues (1998).

Overall, 8% of Maine's household population, or approximately 75,600 persons, were determined to be in need of treatment for dependence on alcohol or illicit drugs in the year prior to the 1997 survey. More than 20% of the household population (upwards of 194,000 persons) were determined to be in need of either treatment or intervention for alcohol or drug abuse. For the majority of cases, need for treatment stemmed from abuse of or dependence on alcohol. This survey also yielded estimates of treatment need by region; specifically, an estimated 28,800 household residents in Region I were in need of treatment for alcohol or drug abuse or dependence, as were 28,300 persons in Region II and 18,400 persons in Region III. (Regional estimates are rounded to the nearest 100th.) Across all regions, men were far more likely to be in need of treatment than women.

As noted in the final report for Study 1 (Kroutil et al., 1998), these figures likely underestimate the actual level of need for treatment statewide because estimates are based on

a survey of household residents with telephones. To the extent that substance use is more prevalent among the homeless or the very poor, the need for treatment is likely greater than depicted in Table 1. Study 2 addressed this issue in part by focusing on one segment of the nonhousehold population (adult arrestees). Study 4 was designed to measure statewide need for treatment more broadly, by utilizing synthetic estimates derived from various social indicators of alcohol and drug abuse and dependence. The combined estimates for substance abuse treatment needs throughout Maine's population are provided in the integrative report developed under Study 6 (Kuo et al., 1999).

Table 1. Estimated Numbers of the Maine Adult Household Population in Need of Alcohol or Illicit Drug Use Treatment or Intervention in the Past Year: 1997

Measure	Percentage	Number[1]	95% CI[2]
Any Need for Treatment[3]			
Alcohol or illicit drugs	8.07	75,600	67,700 - 84,300
Alcohol	7.03	65,900	58,700 - 73,900
Any illicit drugs[4]	1.97	18,400	14,500 - 23,400
Any Need for Treatment or Intervention[5]			
Alcohol or illicit drugs	20.78	194,700	182,300 - 207,600
Alcohol	18.74	175,600	163,800 - 188,100
Any illicit drugs[4]	4.59	43,000	37,100 - 49,800

[1]Estimated number of people rounded to the nearest 100th. Because of rounding and estimation procedures, the sum across regions may differ from the state total estimate. Unweighted numbers of respondents and standard errors for percentages are reported by Kroutil and colleagues (1998).
[2]The 95% CI = the 95% confidence interval for the estimated number of people.
[3]Includes people who (a) received detoxification services or formal treatment in the past 12 months or (b) met lifetime *DSM-III-R* (APA, 1987) criteria for dependence or abuse for a given drug covered in the telephone survey, used the drug in the past 12 months, and had one or more symptoms in the past 12 months or had a problem pattern of use in the past 12 months. See Appendix E of the household survey report for a detailed discussion of how the need for treatment was defined.
[4]Includes marijuana or hashish, hallucinogens, cocaine (including crack), heroin/opiates, or stimulants.
[5]Includes people in need of treatment, as defined above. Also includes people who never met lifetime *DSM-III-R* (APA, 1987) criteria for dependence or abuse for any drugs covered in the telephone survey but who nevertheless had one or more symptoms in the past 12 months or had a problem pattern of use in the past 12 months. See Appendix E of the household survey report for a detailed discussion of how the need for treatment or intervention was defined.

Source: Maine Household Telephone Survey: 1997.

1.3.2 Met/Unmet Demand for Treatment

Table 2 provides additional information on the demand for substance abuse treatment among Maine's household population (Kroutil et al., 1998). As shown, about 2.8% of the household population (or about 26,400 persons) received some type of formal treatment or counseling for substance abuse in the year preceding the telephone survey. Importantly, only 0.6% of the household population (or about 5,500 persons) had received treatment from a detoxification, residential, or outpatient treatment program in the preceding 12 months. When comparing these numbers to the more than 75,600 household residents determined to be in need of formal treatment, we see that the treatment gap is extremely wide—that is, only 7% of those determined to be in need of formal treatment actually sought and received treatment. Just over 1% of the household population (or roughly 9,700 persons) expressed an unmet demand for treatment in the previous year; that is, these individuals felt a need for treatment but received either no treatment or less treatment than they desired. Clearly, then, the distinction between need and demand is critical. This study may be used to assess the ability of the treatment system to meet both demand and need for treatment for the household as well as the nonhousehold populations in the state.

Table 2. Demand for Treatment Services in the Past Year in the Maine Adult Household Population: 1997

Measure	Percentage	Number	95% CI[1]
Received Assistance			
Any assistance[2]	2.8	26,400	21,800 - 31,800
Treatment[3]	0.6	5,500	3,500 - 8,500
Other assistance[4]	2.7	25,000	20,700 - 30,300
Unmet Demand			
Any unmet demand[5]	1.0	9,700	7,100 - 13,400
Wanted additional services[6]	0.7	6,700	4,600 - 9,800
Felt the need for treatment but did not receive assistance	0.3	3,100	1,700 - 5,500

Note: Unweighted numbers of respondents and standard errors for the percentages are reported in the (Maine household telephone survey final report (Kroutil et al., 1998)).

[1]The 95% CI = the 95% confidence interval for the estimates.
[2]Any receipt of treatment or other forms of assistance in the past 12 months for alcohol or other drug abuse, as described in footnotes 3 and 4.
[3]Received detoxification, residential treatment, halfway house services, or outpatient treatment in the past 12 months.
[4]Received mental health counseling for substance abuse, attended self-help groups, received pastoral counseling, or attended an operating-under-the-influence (OUI) program such as DEEP (Driver Education Evaluation Program) in the past 12 months.
[5]Wanted additional treatment or other services in the past 12 months or felt the need for treatment in the past 12 months but did not receive assistance.
[6]Received at least some assistance for alcohol or drug abuse but wanted additional services.

Source: Maine Household Telephone Survey: 1997.

2. DATA SOURCES

In this chapter, we describe the various sources of data used in our analysis of the current treatment system as well as our strategy for estimating the capacity and utilization of the system.

2.1 Existing Data

Limited data on the availability and utilization of treatment services for alcohol and other drug abuse in Maine are available from a number of sources. Whenever possible, we used existing data to build capacity and utilization estimates, supplementing these data with more detailed information from a survey of the state's treatment providers (described below). The use of existing data permits better comparisons to previously published capacity and utilization estimates. Secondary data sources included the 1997 Uniform Facility Data Set (UFDS) Survey, a subset of 1995 data from the Treatment Episode Data Set (TEDS), and other recently published estimates from the Substance Abuse and Mental Health Services Administration (SAMHSA).

2.1.1 Uniform Facility Data Set

The UFDS Survey is an annual survey conducted by SAMHSA's Office of Applied Studies (OAS). The UFDS was previously known as the National Drug and Alcohol Treatment Utilization Survey (NDATUS). Each year, the UFDS Survey solicits data concerning facility and client characteristics from a census of all known treatment programs. "Known" facilities are those state-recognized treatment programs included on the National Facility Register (NFR). The NFR listing is compiled by state and federal agencies that fund, license, or regulate providers of substance abuse programming. Although the NFR is primarily made up of treatment programs, it also includes organizations that provide prevention, intake, and assessment services. Treatment providers most likely to be excluded from the NFR are private-sector programs operating in states with no specific licensure or monitoring requirements for facilities that do not receive state funds.

The UFDS Survey collects capacity and utilization data for one reference day out of the year. (In 1997, the reference day was October 1.) Thus, the UFDS Survey provides a one-day "snapshot" of the treatment system, which can be considered a good indicator of the range of treatment services available nationwide each year. A copy of the 1997 UFDS survey is included in ***Appendix A***.

2.1.2 Treatment Episode Data Set

UFDS is one of two ongoing sources of national data on substance abuse treatment programming. The other source is the Treatment Episode Data Set (TEDS), formerly known as the Client Data System (CDS). TEDS provides descriptive information about the flow of admissions to substance abuse treatment programs nationwide. Like the UFDS Survey, programs responding to TEDS are typically those funded with state or federal dollars. SAMHSA estimates that TEDS covers 91% of all admissions to TEDS-eligible treatment providers, which is 76% of admissions to all known treatment programs. Missing from TEDS are those providers reporting to other agencies, such as the Bureau of Prisons, Veterans' Administration (VA), and Indian Health Service.

Within each state, treatment providers that receive any state agency funding, including Federal Block Grant monies, are expected to provide TEDS data for all clients admitted to treatment, regardless of the source of funds with which the individual clients pay for their treatment. In Maine, private facilities and solo practitioners also contribute data to TEDS. TEDS includes both a minimum data set (required reporting) and a supplemental data set (optional reporting). Programs typically collect the TEDS data from each patient during the treatment intake interview using state-specific administrative forms. States are permitted to collect the data in formats differing slightly from the TEDS data codes, as long as the state is able to collapse or recode the collected data into the standard format used in TEDS. Programs report data to the state, which then incorporates this information into its data system. The state data are transformed into TEDS elements using an approved protocol. The data are transmitted monthly or quarterly to a SAMHSA contractor for processing.[1]

[1]The *Treatment Episode Data Set State Instruction Manual: Admissions Data* is available from the SAMHSA Web site (http://www.samhsa.gov:80/oas/teds/tedsmtoc.htm) and provides complete information on how TEDS data are processed and submitted.

For this study, we draw upon the public use file containing TEDS admission data from 1995. The Interuniversity Consortium for Political and Social Research (ICPSR) distributes the public use data files and maintains a Web site where this and other substance abuse and mental health data sets can be reviewed and working data sets can be created and downloaded (http://www.icpsr.umich.edu/samhsa). A working data set containing only 1995 TEDS data for Maine was created for the supplemental analyses for this study. (Data from 1996-97 were not available for public access at the time these analyses were conducted.)

Because of concerns about releasing potentially identifying information on treatment clients, ICPSR and the National Opinion Research Center (NORC) take several precautions with these data:

- Individual client birth dates (required for TEDS) are removed from the data set and replaced with a calculated age variable;
- Treatment program identifiers also are removed from the public use files; and
- The public use data files contain only a 25% sample of all admissions reported for the year.

In all, the Maine public use data file for 1995 contains 2,009 admissions. Thus, there are two key limitations to TEDS data. First, the unit of analysis is treatment *admissions*, not clients—a client admitted to treatment more than once during the year will appear multiple times in TEDS. Second, because the public use file contains only a subset of the full TEDS data file, these data cannot be used to estimate numbers of admissions. However, because the subset is based on a random sample of cases, the data can provide good estimates of the characteristics of all treatment admissions to TEDS-eligible programs in 1995. A codebook for the working data set, including definitions of the various data elements, is included in ***Appendix B*****.**

TEDS provides a range of sociodemographic and other information on treatment admissions, including age, gender, marital status, education, employment status, living arrangements, primary source of income, expected source of payment, service setting (detoxification, residential, outpatient), referral source, number of prior treatment episodes, substance(s) abused (primary, secondary, tertiary), route of administration, frequency of use, age of first use, and whether the client presented with psychiatric problems in addition to an alcohol or drug problem. Typically, TEDS also provides information on the number of days

waited prior to admission, permitting some estimation of excess demand for treatment services. Unfortunately, Maine does not report this information to TEDS; it is, therefore, not included in this report.

2.2 Provider Survey

The UFDS and TEDS represent two important efforts by SAMHSA to estimate the capacity and utilization of the Nation's treatment system. However, these two sources alone cannot provide all of the information necessary to analyze the structure, capacity, and utilization of Maine's treatment system. Because the data sets use two different time frames, the distribution of clients across levels of care as indicated in UFDS will differ from the distribution reported each year by TEDS. For that reason, we used UFDS data in this report to estimate the capacity and structure of treatment programs, while TEDS data were used only to describe the characteristics of patients admitted to treatment. Although UFDS is useful for establishing the static capacity of the treatment system and TEDS speaks to utilization rates, neither data set alone is suitable for generating reliable estimates of the dynamic capacity of the treatment system (i.e., the client capacity over the course of 1 full year).

The UFDS and TEDS also do not provide much detailed information on the specific types of treatment services offered or received. The UFDS Survey collects data on three broad categories of services—detoxification (hospital and residential), rehabilitation (hospital and residential), and outpatient (including intensive outpatient) care, but little information is collected on the clinical processes associated with these services. Finally, because only 65% of the treatment programs being considered in this study responded to the 1997 UFDS Survey, missing information reduced the accuracy of capacity and utilization estimates that could be generated using these data alone. To improve the completeness of the available data on services, capacity, and utilization, we incorporated an additional source of information into Study 5.

We prepared a brief questionnaire designed to supplement and complement the UFDS Survey, while providing additional information on managed care, staffing, and other topics not covered in the UFDS. Staff from OSA distributed the questionnaires to 152 treatment providers identified as eligible for inclusion in this study. Target respondents were drawn from the state's

existing list of recognized substance abuse service providers.[2] (This list is included in ***Appendix C***, along with information on the sources of data obtained from each program. Facilities considered ineligible for inclusion in the study are indicated.) We omitted from our distribution list all programs that were not part of the formal treatment system (such as 12-step groups) as well as programs that provided prevention or referral services exclusively. Also excluded were programs not open to the general public, such as counseling programs run by the military or postal service, VA hospitals, and correctional facilities. The agencies that were judged as ineligible for the survey are identified in the list of 193 providers (Appendix C) recognized by OSA as substance abuse service providers. The limitations of this sampling frame and the resulting data are described in more detail in Section 2.5.

Reference dates were used to establish the time periods within which a given number of patients could be treated in each program. All providers were asked to report point-prevalence data for the same date and annualized data for the same year. Because the UFDS Survey uses October 1 as its reference date, we used the same date—and October 1, 1996, to September 30, 1997, as the reference year—to obtain information that would correspond to the UFDS data. A copy of the questionnaire used in this study is provided in ***Appendix D***.

The questionnaire covered the following topics:

- Program capacity and utilization: average daily census, number of beds, number of outpatient sessions offered, number of staff, average length of stay (by level of care), total annual admissions (duplicated and unduplicated), and special populations served;
- Referral and outreach: amount of time devoted to various outreach activities and primary referral sources for clients; and
- Clinical process: intake procedures, assessment services, case management activities, therapeutic emphases, frequency of individual and group counseling, treatment goals, ancillary services offered, and discharge procedures.

Programs also reported their payer mix as well as information about the impact of managed care on the organization and delivery of substance abuse treatment services. Although these

[2]The master list of service providers from which our sample was drawn may be found in *Maine Alcohol and Other Drug Abuse Services* (Maine OSA, 1997). This file may be accessed via the Internet at http://www.state.me.us/dmhmrsa/osa/pdffile/servdir.pdf.

questionnaires gathered a significant amount of useful information, much is beyond the scope of this report. For the most part, we focused on information about program capacity and utilization.

A total of 80 programs responded to the OSA survey. To produce reliable capacity and utilization data, a brief (one-page) questionnaire covering only the essential capacity and utilization items was faxed to those programs that had not responded to either the UFDS or OSA surveys. This approach resulted in at least a minimum set of data from nearly all of the state's eligible programs. The population surveyed and the sources of data used in this report are summarized in Table 3.

Table 3. Treatment Programs Providing Data for Study 5

Sampling frame	n = 193 service delivery units
Eligible facilities	n = 152 service delivery units (135 programs[1])
Data received	
Any data	132 programs (97.8%)
1997 UFDS only	35 programs (25.9%)
UFDS and OSA surveys	27 programs (20.0%)
OSA survey only	53 programs (39.3%)
Core items only	20 programs (14.8%)
None	3 programs (2.2%)

[1]Statewide, there are a number of treatment programs that operate treatment clinics or service delivery units at several different locations. In the process of responding to either the UFDS or OSA surveys, several of these treatment programs provided aggregated data for multiple service delivery units. Although this reduces the effective number of respondents for the study, it has no negative effect on the validity of our estimates, as each of these service delivery units (SDUs) is included in the aggregated data.

Source: Assessment of Maine's Substance Abuse Treatment System: Structure, Capacity, and Utilization: 1999.

2.3 Treatment Providers

The substance abuse treatment providers included in this study are limited to state-funded programs within the formal treatment system. The scope of the formal treatment system includes all residential (hospital and nonhospital) and outpatient drug-free substance

abuse treatment facilities. This grouping does not include services provided by physicians or counselors in private practice, employee assistance programs (EAPs), or support/self-help groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).

There are a number of reasons for limiting the scope of this report to the formal treatment system. First, although health care providers outside the formal treatment system, such as primary care physicians, may frequently encounter individuals who have symptoms related to alcohol or other drug abuse, rarely is treatment for substance abuse within the scope of their services. Similarly, EAPs generally provide only assessment services; employees requiring substance abuse treatment are referred to an appropriate treatment facility. Importantly, both EAPs and private-practice therapists provide services for a broad range of problems, not just substance abuse; it is, therefore, difficult to determine capacity and utilization estimates for that subset of individuals requiring alcohol or drug abuse treatment. Finally, tracking and obtaining information from AA, NA, and other self-help programs not affiliated with the formal treatment system is not feasible given that these groups have anonymity as a core precept.

2.3.1 Types of Treatment

This report provides data on capacity and utilization of treatment services in three types of care. Our definitions of these modalities are consistent with those used in the UFDS Survey (SAMHSA, 1998):

Detoxification (24-hour care): The process of supervised withdrawal from drugs or alcohol within a short time, usually 1 week or less. Formal, medically supervised detoxification may include the use of medication to ameliorate withdrawal and reduce associated discomfort. Detoxification can be an emergency procedure for drug overdoses, but it typically requires care on less than an emergency level.

> *Hospital inpatient detoxification* refers to 24-hour-per-day medical acute care services for detoxification for persons with severe or medical complications associated with withdrawal.
>
> *Residential detoxification* refers to 24-hour-per-day services in a nonhospital setting that provide for safe withdrawal and transition to ongoing treatment.

Rehabilitation (24-hour care): Includes hospital inpatient, nonhospital short-term care, and nonhospital long-term care.

Hospital inpatient rehabilitation refers to 24-hour-per-day medical care in a hospital facility in conjunction with treatment services for alcohol and other drug abuse and dependency.

Residential rehabilitation refers to residential nonacute care in a setting with treatment services for alcohol and other drug abuse and dependency. May include transitional living arrangements such as halfway houses.

Outpatient (Less than 24-hour care): Includes individual and group counseling where a client does not stay overnight in a treatment facility; these services may be offered with or without medication. Both outpatient and intensive outpatient modalities are included in this category.

Intensive outpatient treatment involves services provided to a client that last 3 or more hours per day for 3 or more days per week. Day treatment or partial hospitalization services are included in this category.

Outpatient services are those rehabilitation, counseling, and supportive services offered less frequently than intensive outpatient services.

Table 4 shows the distribution of outpatient, rehabilitation, and detoxification services across each of the state's three regions for the providers discussed in this report.

Table 4. Services Provided, by DMHMRSAS Region: 1997

	Number of Programs				
		Outpatient		Inpatient	
Region	Total[1]	Intensive	Non-intensive	Rehab	Detox
I	35	5	28	14	7
II	61	6	55	9	7
III	39	3	38	5	7
Statewide	135	14	121	28	21

[1]Rows do not add up to the total because programs may offer multiple levels of care.

Source: Assessment of Maine's Substance Abuse Treatment System: Structure, Capacity, and Utilization: 1999.

2.4 Determining Treatment Capacity and Utilization

Analyses presented in this report include estimates of both capacity and utilization of the treatment system. Capacity addresses the supply side of the treatment equation. Meanwhile, utilization equates to met demand. Utilization involves the number of clients in treatment on a given day and throughout an entire year. Capacity is somewhat more difficult to define. Because patients vary in the amount of time they spend in treatment and because these variations are evident across treatment modalities, we include two different measures—static capacity (a point-prevalence or snapshot measure) and dynamic capacity (an annual estimate).

2.4.1 Static Capacity

We estimated static capacity by recording the number of treatment slots for detoxification, rehabilitation, and outpatient treatment that could have been filled at each treatment program on October 1, 1997. Static capacity estimates are point-prevalence data drawn first from the UFDS Survey, with responses from the provider survey used to fill in missing information. For inpatient/residential detoxification and rehabilitation services, static capacity refers to the number of beds. Determination of static capacity for outpatient services requires a different approach. Unlike inpatient treatment, where treatment slots are well-defined (i.e., number of beds), outpatient capacity varies with the number of patients who can be accommodated in a treatment group and with the number of group and individual sessions that can be offered over a given period of time. Both the number of sessions and the session capacity are fundamentally determined by the number of counselors a program has on staff. Many programs use a combination of full-time, part-time, and contracted counselors for their outpatient programming and can adjust the number of staff as demand for treatment increases or decreases. In other words, the capacity of outpatient treatment modalities is largely elastic. *We assume that programs are retaining the minimum number of staff necessary to accommodate their current patient caseload; that is, we assume little or no slack in outpatient treatment capacity.* For this reason, in our analyses, static outpatient capacity is equivalent to each program's average daily outpatient census for the preference year of the OSA provider survey. We provide estimates for each of the three substate Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) regions.

2.4.2 Dynamic Capacity

Although it is useful to obtain a count of treatment slots available on a given day, it is perhaps more important to determine the *dynamic capacity* of the treatment system. By referring to capacity as dynamic, we refer to the capacity of the system over a given period of time. For Study 5, we sought to provide annual estimates of system capacity—that is, the number of patients who could be treated over the course of 1 full year. Determination of dynamic capacity requires looking beyond the number of treatment slots available to examine the flow of clients through those slots.

Because point-prevalence estimates do not yield a complete picture of system capacity, several dimensions of substance abuse treatment must be considered. First, clients have different lengths of stay or retention rates in treatment programs. This is attributable to differences across treatment modalities (e.g., detoxification requires shorter stays than long-term residential care), as well as to differences across patients in treatment compliance. Second, intensity of treatment varies across clients, due in large part to differences in severity of substance abuse or dependence. Third, retention and turnover rates vary across clients and programs; clients may or may not complete a treatment episode, and some clients will re-enter the system multiple times. Data collected for this study include estimates of the average length of stay by treatment modality, as well as client readmission and turnover rates for individual providers and for the treatment system as a whole.

A brief example illustrates the important contribution of dynamic capacity estimates to an overall understanding of the treatment system's capacity. If a treatment program has 10 beds, its static capacity is 10—that is, only 10 patients can be in treatment at any given time. If those beds are used for inpatient rehabilitation services and the average length of stay in detoxification is 5 days, then 73 patients (365/5) can be treated per bed per year; in other words, the program's dynamic capacity over the course of 1 year is 730 (73 patients x 10 beds), assuming perfect efficiency. However, suppose there is another facility that has 10 beds for its rehabilitation program, but its average length of stay is 15 days. That program could treat approximately 23 patients (365/15) per bed per year, for a total of 230 patients annually. Thus, as a snapshot of the treatment system, these two programs appear to have the same capacity, but over the course of 1 year, one program will treat substantially more patients than the other. The dynamic nature of treatment is an essential consideration if capacity estimates are to be meaningfully calculated.

The dynamic capacity of the treatment system was estimated as follows:

Detoxification and Rehabilitation. Total annual capacity was calculated as follows:

$$\frac{\text{365 days x number of beds}}{\text{avg. length of stay}}$$

Outpatient Treatment. Outpatient capacity estimation is more complicated because treatment is sometimes offered in a group setting. The more patients that can be accommodated in a group, the greater the annual treatment capacity. However, the longer the length of stay in treatment, the fewer patients who can be treated per slot per year. We provide separate capacity estimates for intensive and nonintensive outpatient services. As described earlier, intensive outpatient services include sessions offered at least 2 hours per day at least 3 days per week. Standard outpatient care includes sessions offered less than 3 days per week (typically one session per week). These distinctions follow the patient placement criteria established by the American Society of Addiction Medicine (ASAM).

Because we assume little or no slack in staff resources devoted to outpatient treatment, a program's dynamic outpatient capacity should be approximately equivalent to its annual admissions. That is, if we assume that a program is retaining the minimum number of counselors to serve its average daily caseload, then the number of patients served in a year is the true measure of capacity. The number of annual admissions divided by a program's static capacity yields an estimate of the average length of stay in treatment. If additional resources were made available for counseling staff, program capacity could be expanded. (Program capacity also could be expanded by decreasing the average length of stay or expanding the patient/counselor ratio, but these are typically not reasonable approaches to improving patient outcomes.) Although admissions should provide reasonable dynamic capacity estimates, we thought it would be useful to compute estimates of annual outpatient capacity based on the average length of stay (ALOS) and static capacity data from the provider survey. Section 3.2.2 provides the process we followed, with the results in Table 6c. In addition to providing information on annual admissions, we also provide regional estimates of the number of additional treatment slots that would be gained for each full-time equivalent (FTE) counselor added to a program's staff.

2.4.3 Utilization

Information on utilization is drawn from multiple sources. The OSA survey yielded information on each program's average daily census across each level of care; this figure allowed us to make comparisons across treatment providers regarding the number of clients in treatment at any given time. These numbers can be mapped against regional estimates of treatment need developed through the other components of this comprehensive needs assessment project. We also used information on the number of annual admissions to compare the total number of clients admitted to each level of care between October 1, 1996, and September 30, 1997 with regional and statewide estimates of need for treatment. These data were then aggregated to provide regional utilization figures.

Along with estimates of the number of admissions and utilization rates, we also provide information about the characteristics of clients admitted to treatment in Maine treatment facilities. Data for calendar year 1995 (the most recent year available) were obtained from the TEDS data system. Although data were not available for the same time period as the OSA survey (fiscal year [FY] 1997), it is important to note that nationally throughout the 1990s TEDS data have shown remarkably little year-to-year fluctuations in client characteristics. Information obtained from TEDS is an important supplement to the utilization data because it permits a better understanding of the types of clients who are most likely to seek and enter treatment. However, current treatment clients may differ considerably from the set of persons in the state who need treatment. To the extent that such clients differ systematically from all individuals needing substance abuse treatment, treatment or intervention services can be directed toward those individuals whose treatment needs have traditionally gone unmet.

2.5 Limitations of this Report

This study provides important information about the capacity and utilization of Maine's formal substance abuse treatment system. However, there are a number of limitations to the scope and content of this report. Perhaps most importantly, two key segments of the formal treatment system were not included in the provider survey conducted as part of Study 5. Private-sector programs (those operating without any state funding and not on the OSA agency list) and methadone maintenance programs were not surveyed. The lack of data from private providers is a potentially important limitation, and this should be a key point of inquiry for the next round of needs assessment activities in the state. However, the state's immediate need is for information on the number and availability of treatment slots supported by state dollars; this

information is essential for resource allocation decisions. The private sector, although an important source of treatment services, typically serves a different population than the public sector and is less affected by state-level funding decisions. Similarly, methadone maintenance represents a fundamentally different treatment approach than drug-free modalities, and the characteristics of methadone patients, the prevalence of heroin abuse, and Maine methadone treatment slots and utilization rates have been remarkably low and stable over time, lessening the need for current estimates of capacity and utilization.

Similarly, it should be recognized that although this report focuses on that portion of the formal treatment system supported in whole or in part by state funds, individuals can seek and receive treatment from any number of sources. Service providers outside the formal system can often be important referral routes through which patients access (or are diverted from) the formal treatment system; exploration of such organizational linkages is beyond the scope of this report. Also excluded from this report are facilities providing substance abuse counseling in support of or incidental to a primary service, including correctional facilities and psychiatric hospitals. Similarly, this report focuses on three general treatment modalities (detoxification, rehabilitation, and outpatient care); programs exclusively providing other types of intervention or reintegration services are not covered in these analyses.

Finally, our analyses focus exclusively on the capacity and structure of the treatment system, assuming continuity and stability in organizational structure and resources. The data sources for this report allow us to make a broad assessment of the number of patients that can be (and have been) treated in these programs; however, this study was not intended to assess the efficiency or effectiveness of the services offered. Ongoing and continuing research will help to link organizational structure and performance with capacity and utilization in order to best determine whether resources are allocated adequately and equitably across the DMHMRSAS regions.

3. CAPACITY AND UTILIZATION OF THE TREATMENT SYSTEM

This chapter presents findings obtained from analyses of the provider surveys, the 1997 Uniform Facility Data Set (UFDS) data, and the 1995 Treatment Episode Data Set (TEDS) data. These sources were used to derive estimates of the capacity of the treatment system on a given day as well as over the course of a year. Additionally, we drew upon TEDS data to describe the characteristics of clients admitted to treatment in a recent and representative year. Together, this information allows for an assessment of the number and characteristics of clients typically treated in Maine's formal treatment system.

3.1 Static Capacity

Table 5 presents estimates of the static capacity of Maine's state-approved substance abuse treatment programs. Separate estimates are provided for intensive and nonintensive outpatient and for detoxification and inpatient rehabilitation treatment modalities across each of the state's three Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) regions. As shown, the 135 treatment programs surveyed report that they can accommodate about 7,516 patients in outpatient services on any given day, while about 450 beds are available for detoxification, inpatient care, or residential rehabilitation services on any given day. Average daily census figures show that approximately 58% of all clients receiving some form of inpatient care are in residential rehabilitation services (with the remainder in short-term detoxification). Region I includes the majority of inpatient treatment slots, while Region III reported the greatest number of outpatient slots.

Table 5. Estimated Static Capacity of Maine's State-Approved Treatment Programs, by Modality and DMHMRSAS Region

	Treatment Modality[1]			
	Outpatient		Inpatient	
Region	Intensive	Nonintensive	(Detox + Rehab)	Overall
I	49	1,908	250	2,207
II	44	2,085	112	2,241
III	54	3,376	89	3,519
Statewide	147	7,369	451	7,967

[1]For reasons described in the text, static outpatient capacity was assumed to equal average daily outpatient census. Inpatient includes both detoxification and rehabilitation services and is based on the number of beds that could have been used for substance abuse treatment on the reference date.

Source: Assessment of Maine's Substance Abuse Treatment System: Structure, Capacity, and Utilization: 1999.

3.2 Dynamic Capacity

As noted in Chapter 2, the dynamic capacity of the treatment system is difficult to estimate with precision for a number of reasons. The capacity of inpatient (rehabilitation and detoxification) services is limited by the number of available treatment beds in a facility and by the average length of stay (ALOS) for patients in treatment. As shown in Table 6a, the typical length of stay for patients in detoxification was about 4 days, while the typical length of stay for patients in residential rehabilitation programs was in excess of 100 days. Outpatient clients had much longer ALOS.

Table 6a. Estimated Average Length of Stay, by DMHMRSAS Region and Modality[1]

	Inpatient		Outpatient	
Region	Detox (days)	Rehab (days)	Intensive (sessions/weeks)[2]	Nonintensive (weeks)
I	4	146	39/13.0	13
II	4	163	14/4.7	14
III	3	103	16/5.3	14

[1]Information obtained from survey data (*N* = 80 programs or 59% of eligible respondents). The typical length of stay for programs not providing data may differ from the programs on whose data these estimates are based.
[2]Number of weeks was computed based on three sessions per week.

Source: Assessment of Maine's Substance Abuse Treatment System: Structure, Capacity, and Utilization: 1999.

3.2.1 Inpatient Services

Using the ALOS data in Table 6a, along with the approximate proportion of beds devoted to detoxification and rehabilitation services, estimates of the dynamic capacity for inpatient services were developed and are shown in Table 6b. These estimates suggest that more than 11,000 patients *could* receive inpatient care over the course of an entire year were the treatment system operating at full capacity (and assuming perfect efficiency). Thus, despite the relatively small number of beds available on any given day, quite a large number of patients could be treated over an entire year, especially in detoxification programs due to the short ALOS. However, caution must be used when interpreting these figures. There are various demands on personnel and other resources that programs must expend to offer these services. If a program offers multiple levels of care, staff time may need to be split between various services; therefore, the dynamic capacity estimates would show the number of patients who could be treated in a year if the necessary current operational resources could be devoted exclusively to those services. In addition, these estimates assume perfect efficiency in the

system—that is, one patient is admitted on the same day another is discharged, with no lag in services. It is highly unlikely that perfect efficiency will exist in Maine's or any similar system, and adjustments for inefficiencies will need to be made to arrive at operationally reasonable dynamic capacity estimates.

Most important, it should be noted that the vast majority of this estimated capacity is attributable to detoxification services. Detoxification is, by definition, a medical procedure used to stabilize patients in withdrawal; it is not an intensive treatment regimen and cannot effectively be used to divert patients from more intensive substance abuse treatment. In other words, although increasing access to detoxification services is a valued goal when those services are needed, programs would not serve their patients well by utilizing excess detoxification capacity for the treatment of patients who require longer-term inpatient or outpatient rehabilitation. In addition, it should be noted that detoxification programs rarely are able to sustain full capacity for a number of reasons, including mismatches in the time or location where patients need treatment and services are available. On the other hand, the estimated dynamic capacity for residential rehabilitative care better approximates the true capacity of that portion of the treatment system, because these services tend to have waiting lists and thus treatment slots, when available, can be filled fairly rapidly.

Table 6b. Estimated Dynamic Capacity for Inpatient Services, by DMHMRSAS Region

		% Beds used for		ALOS (days)		Estimated Total Inpatient Dynamic (Annual) Capacity[1]		
Region	**Beds**	**Detox**	**Rehab**	**Detox**	**Rehab**	**Detox**	**Rehab**	**Total**
I	250	19.2	80.8	4	146	4,380	505	4,885
II	112	29.7	70.3	4	163	3,035	173	3,208
III	89	30.6	69.4	3	103	3,309	219	3,528
Statewide	451					10,724	897	11,621

[1]Dynamic capacity estimates were derived using the formula shown in Section 2.4.2. Capacity estimates provided here are likely to be 2% to 4% underestimated based on information for each of four service delivery units that were excluded.

Source: Assessment of Maine's Substance Abuse Treatment System: Structure, Capacity, and Utilization: 1999.

3.2.2 Outpatient Services

We indicated earlier that because of the flexibility in reacting to the demand for outpatient services, it was reasonable to assume that on average static capacity was equal to demand. Based on this assumption, one could then assume that dynamic (annual) capacity equals annual admissions. Nonetheless, it is interesting and useful to compute estimates of annual outpatient capacity based on the static capacity and average length of stay reported by the responding programs in the Office of Substance Abuse (OSA) survey.

Estimates of dynamic capacity by DMHMRSAS region are shown in Table 6c. These estimates are based on the static capacity and ALOS estimates shown in Tables 5 and 6a, respectively, and computed as described below.

The following equation calculates the dynamic (annual) capacities for outpatient services:

$$\text{(Static capacity)} \left(\frac{52 \text{ weeks}}{\text{ALOS (in weeks)}} \right) .$$

Table 6c. Estimated Dynamic Capacity for Outpatient Services, by DMHMRSAS Region

Region	Intensive[1]	Nonintensive	Total
I	196	7,632	7,828
II	488	7,714	8,202
III	529	12,487	13,016
Statewide	1,213	27,833	29,046

[1]Dynamic capacity estimates were derived as described in Section 3.2.2. Estimates are for admissions. Capacity estimates provided are likely 2-4% underestimated based on the each of information for 4 service delivery units that were excluded.

Source: Assessment of Maine's Substance Abuse Treatment System: Structure, Capacity, and Utilization: 1999.

Intensive Outpatient

The information in Table 6a shows the number of intensive outpatient sessions per service admission by region, specifically 39, 14, and 16 for regions I, II, and III, respectively. It is not clear why the number of sessions varies across regions; however, the service providers consistently reported an average of three sessions per week for intensive outpatient clients. Thus, the dynamic capacity for each region was computed based on an ALOS (in weeks) of

13.0 for Region I, 4.7 for Region II, and 5.3 for Region III. Therefore, the region's static capacity was multiplied by 4.0 for Region I, 11.1 for Region II, and 9.8 for Region III to arrive at dynamic capacity.

Nonintensive Outpatient

The average lengths of stays for nonintensive outpatient services are 13 weeks, 14 weeks, and 14 weeks for Regions I, II, and III, respectively. Thus, the dynamic capacity for each region is the static capacity multiplied by 4.0 for Region I, 3.7 for Region II, and 3.7 for Region III.

The dynamic capacity estimates based on the process described above are shown in Table 6c.

Our estimates of the system's capacity for outpatient services are conditioned by assumptions about the availability of personnel and other resources. As explained in Chapter 2, we made two assumptions about outpatient capacity. First, we assumed that treatment facilities are maintaining the *minimum* number of counselors necessary to accommodate their average daily census. Second, we assumed that there is little or no slack in the resources devoted to outpatient treatment. That is, substantial increases in program capacity are dependent upon accompanying increases in personnel resources. To estimate the net gains in outpatient capacity that could be realized by increasing a program's personnel resources, we asked each program to report the number of counselors (full-time equivalents [FTEs]) devoted to maintaining their current outpatient caseloads. The average patient-to-counselor ratio for outpatient services statewide was 21 to 1 (although there was considerable variation between programs). Thus, for every additional counselor devoted to outpatient treatment services, an additional 21 patients could be accommodated; statewide, the addition of one full-time counselor at each of the 123 programs that offer outpatient services would increase the system's capacity to provide outpatient services by 2,583 treatment slots.

3.3 Utilization

Each of the 135 responding treatment programs provided information on their average daily census by modality (outpatient, rehabilitation, detoxification) and their total annual admissions for the reference year. These figures, when compared to the capacity estimates presented above, provide an indication of the extent to which the system was utilized during the

reference year. Daily utilization estimates are shown in Table 7a and annual utilization estimates in Table 7b.

As shown in Table 7a, the 135 programs were treating approximately 7,780 persons on any given day during the reference year (October 1, 1996, to September 30, 1997). The vast majority of these patients (7,516 or 97%) were receiving outpatient care, with about 3% of all patients receiving inpatient or residential rehabilitation services. As is clear from the daily census versus the overall static capacity numbers, the overall system was operating at very near capacity (98%) on an average day during the reference year. Because of inherent inefficiencies in operating a service system such as a substance abuse services system at 100% of theoretical capacity, a target of 85% to 90% is usually considered full capacity.

Table 7a. Average Daily Program Utilization, by DMHMRSAS Region: 1997

Region	Average Daily Census			Total Daily Census	Static Capacity[1]
	Outpatient	Rehab	Detox		
I	1,957	109	26	2,092	2,207
II	2,129	64	27	2,220	2,241
III	3,430	26	12	3,468	3,519
Statewide	7,516	199	65	7,780	7,967

[1]These numbers include duplicate admissions (i.e., each admission during the year for a patient with multiple admissions is counted). Estimates are for the year October 1, 1996, to Septemter 30, 1997.

Source: Assessment of Maine's Substance Abuse Treatment System: Structure, Capacity, and Utilization: 1999.

Total annual admissions ranged from about 9,800 patients in Region I to slightly more than 25,000 patients in Region II. Overall, the treatment providers reported 44,935 admissions for the entire reference year. Total dynamic (annual) capacity for the system was estimated at 40,667 (see Table 7b). Thus, on an annual basis, the system was utilized at a rate of about 110%. However, the ratio of reported annual admissions to capacity varied considerable by region, with Region II reporting annual admissions at about 220% of capacity. Admissions can exceed expected capacity by increasing the group size or the patient-counselor ratios of outpatient services or by continuing to carry essentially inactive cases on program rolls. For both outpatient and inpatient services, admissions can exceed expected capacity by experiencing shorter-than-expected average lengths of stays.

Table 7b. Annual Program Utilization, by DMHMRSAS Region: 1997

Region	Annual Capacity			Total Annual Capacity	Total Annual Admission
	Outpatient	Rehab	Detox		
I	7,828	505	4,380	12,713	9,773
II	8,202	173	3,035	11,410	25,060
III	13,016	219	3,309	16,544	10,102
Statewide	29,046	897	10,724	40,667	44,935

[1]These numbers include duplicate admissions (i.e., each admission during the year for a patient with multiple admissions is counted). Estimates are for the year October 1, 1996, to September 30, 1997.

Source: Assessment of Maine's Substance Abuse Treatment System: Structure, Capacity, and Utilization: 1999.

3.4 Estimating the Treatment Gap

An estimate of the size of the treatment gap can be obtained by comparing the estimated need for treatment to the estimated capacity of the treatment system. Table 8 shows the estimated need for treatment for each of the state's three DMHMRSAS regions in 1997. The need for treatment estimates included here are for adults (18 years old or older) and include estimates of need from population subgroups not included in a household survey. The number of patients admitted to programs in the formal treatment system also is shown for each region. The met need is expressed as the percentage of the estimated need that was addressed by the treatment system. As shown, admissions in Region II equaled roughly 81% of the total number of persons in need of treatment. By comparison, programs in Region III admitted roughly 53% of those in need, while programs in Region I admitted about 31% of the number of persons in need of treatment as estimated by the Maine State Needs Assessment Project studies. Note, however, that annual admissions represents a duplicated client count; as a result, these figures may underestimate the size of the treatment gap since one persion is counted more than once for some proportion or admissions.

Table 8. Treatment Need Versus Current Service Levels, by DMHMRSAS Region: 1997

Region	Estimated Need for Treatment[1]	Annual Admissions (all levels of care)	Met Need[2]
I	31,258	9,773	31.2%
II	30,853	25,060	81.2%
III	19,098	10,102	52.9%
Statewide	81,209	44,935	55.3%

[1]From Maine's integrated population estimates (Koo, et al., 1999). These numbers include estimates of treatment need for special population groups in addition to the household population.
[2]Expressed as (annual admissions / estimated need) * 100. This proportion does not account for duplicated admissions and, therefore, likely overestimates the met need.

Source: Assessment of Maine's Substance Abuse Treatment System: Structure, Capacity, and Utilization: 1999.

3.5 Characteristics of Individuals Accessing Treatment

Table 9 presents information on the sociodemographic characteristics of persons admitted to Maine's formal substance abuse treatment system in 1995. This information is drawn from the Substance Abuse and Mental Health Services Adminstration's (SAMHSA's) TEDS; the unit of analysis is treatment admissions rather than individual clients. These data show that individuals admitted to treatment are typically male (75%), between the ages of 25 and 44 (63%), never married (47%), not in the labor force (48%), and with a high school education or less. Consistent with capacity estimates, the vast majority of individuals are admitted to outpatient treatment (71%). Sociodemographic characteristics show little systematic variation within the three treatment modalities; that is, admissions tend to be similarly distributed across demographic categories within outpatient, rehabilitation, and detoxification services. The one exception to this trend is that employed patients tend to receive outpatient care, while persons not in the labor force tend much more often to be admitted to detoxification or rehabilitation services. Additional analyses (not shown) indicate remarkably little variation between men and women in terms of their distribution across treatment modalities and sociodemographic characteristics; that is, roughly the same proportion of women and men were admitted to each of the three types of treatment programs, and they shared similar personal characteristics.

Table 9. Admissions to Maine's State-Approved Treatment Programs: Client Characteristics, by Services Received: 1995[1]

	All Admissions	Services Received		
		Detox	Rehab	Outpatient
Total Admissions	–	(16.2%)	(12.8%)	(71.0%)
Gender				
% Male	74.6	85.7	70.3	72.9
% Female	26.4	14.3	29.7	27.1
Age at Admission				
Under 18	6.8	–	4.7	8.8
18-24	15.2	7.2	13.0	17.4
25-44	63.3	70.4	65.7	61.3
45+	14.6	22.5	16.5	12.5
Education				
0-8 years	10.6	9.0	9.6	11.2
9-11 years	24.8	25.9	25.1	24.5
12 years	46.8	47.6	47.0	46.6
13+ years	17.8	17.6	18.3	17.8
Marital Status				
Married	15.0	4.1	7.9	18.7
Never married	47.3	46.3	47.1	47.5
Separated/divorced/ widowed	37.7	49.6	45.0	33.8
Employment Status				
Full time	24.4	9.3	6.4	30.8
Part time	10.7	4.8	5.1	12.9
Not employed	16.8	16.7	17.4	16.7
Not in labor force	48.1	69.1	71.2	40.0

[1]Unit of analysis is admissions (duplicated client count). From 1995 TEDS public use data file.

Source: Assessment of Maine's Substance Abuse Treatment System: Structure, Capacity, and Utilization: 1999.

Additional data indicate that individuals accessing the treatment system are predominantly polydrug abusers. Data from the 1996 UFDS show that on October 1, 1996, 35% of all patients presented with alcohol problems, 16% were in treatment for drug abuse problems, and 49% required treatment for both alcohol and drug problems (SAMHSA, 1997). The 1995 TEDS data provided more detail. Of patients admitted to treatment in calendar year 1995, 82% indicated primary use of alcohol, while a total of 94% indicated any use of alcohol; 10.5% indicated primary use of marijuana (42.5% reported any use); 2.4% indicated primary

use of cocaine (12.8% reported any use); and 3.2% indicated primary use of opiates (5.8% reported any use).

3.6 Client Turnover and Readmissions

Table 10 includes data obtained from the TEDS public use data file for 1995 and shows the proportion of admissions to each of the three general service categories who had received treatment on one or more previous occasions. Such treatment history variables provide important information on the type of clients being served by the state's treatment system, as well as an indication of the effectiveness of treatment services. As shown, approximately 66% of all admissions in 1995 reported at least one prior treatment episode. Patients admitted to detoxification services were the most likely to have received prior treatment, with 86% reporting any prior treatment and fully 45% reporting three or more prior treatment episodes. As noted earlier in this report, detoxification is not a treatment approach per se but rather can be used for stabilization of patients in crisis (drug overdoses, for example). Unless patients are subsequently referred to a structured treatment program, they are likely to reaccess the system with future needs for crisis management. Thus, the high rate of readmission to detoxification services is not unexpected. Patients admitted to outpatient services in 1995 were least likely to have accessed the treatment system previously, with 40% indicating no prior treatment and an additional 27% indicating one prior episode.

Table 10. Number of Prior Treatment Episodes for All 1995 Admissions, by Level of Care Received

		Level of Care		
Prior Episodes	**All Admissions**	**Detox**	**Rehab**	**Outpatient**
0	32.8%	13.8%	14.4%	40.4%
1	24.6%	13.5%	26.4%	26.8%
2	13.1%	12.3%	14.0%	13.1%
3 or more	28.9%	60.3%	45.1%	26.6%

Note: Data are drawn from the 1995 TEDS public use data file.

Source: Assessment of Maine's Substance Abuse Treatment System: Structure, Capacity, and Utilization: 1999.

Along with the number of treatment slots and counseling staff, another factor in the availability of treatment services is the rate of turnover among clients. As noted elsewhere in this report, none of the data sources used for this study (UFDS, TEDS, or the provider survey) contains information on treatment outcomes or specific details of treatment transactions. Without this information, it is impossible to determine whether the average length of stay or degree of turnover among clients is appropriate or indicative of acceptable program performance. If turnover at one program is low relative to another, it may be because

- the program is inefficient and retains patients for too long,
- the program offers a longer and more effective treatment regimen, or
- the comparison program is inefficient and retains too few patients.

Although treatment outcome data were not available for this study, the provider survey contained several questions that can provide some indication of reasons for client turnover. Programs responding to the OSA survey were asked to report common reasons why patients would be administratively discharged prior to treatment completion. Programs with a high number of administrative discharges may have a greater dynamic (annual) capacity because of greater turnover among their patients; at the same time, programs with more administrative discharges also are likely to be less tolerant of client behaviors such as drug use while in treatment or missed counseling sessions. Thus, these programs tend to discharge patients for noncompliance. This type of turnover is fundamentally different from turnover attributed to successful completion of the prescribed treatment regimen and should be taken into account when interpreting a program's apparent annual capacity. Among the responding programs, 4% said it was very common to discharge patients for use of alcohol or other drugs while in treatment, 6% would discharge patients for missing counseling sessions, and 26% would discharge patients for violating program rules. Each of these different formal or informal discharge policies contributes to the average turnover rate in each program.

As an additional indicator of treatment outcomes, the OSA provider survey asked about each program's criteria for defining a successful treatment outcome and the proportion of patients meeting those criteria in the reference year. Programs had a wide variety of criteria for successful completion of the program, but not surprisingly the most common were "follows treatment plan" (84%) and "remains in treatment for a specified period of time" (37%). On balance, programs reported that about 60% of all patients met the program's definition of

successful completion. Further research is needed to compare the performance of the state's treatment programs using standard measures of treatment outcomes.

3.7 Managed Care

Yet another influence on the availability and utilization of treatment services is the extent to which patients must receive approval for treatment before payment can be rendered. Managed care is increasingly affecting both public and private payers who cover substance abuse treatment services. The OSA survey asked providers a series of questions to determine the current influence of managed care over the substance abuse treatment services offered statewide. Results of these questions are provided in Table 11. As shown, roughly 86% of responding programs noted that managed care creates additional barriers to treatment either nearly always or for some proportion of patients seeking treatment. Just over one third of responding programs felt that managed care organizations do not usually authorize treatment of sufficient type, duration, or quality to produce acceptable outcomes. Also, fully 75% of responding programs indicated that, under managed care arrangements, substance abuse services are not adequately coordinated with other (wraparound) services needed by patients if they are to achieve optimal outcomes. The majority of responding programs reported that, on the whole, managed care's gatekeepers (those authorizing services) were not adequately trained and that the patient placement criteria being used (including the definition of medically necessary treatment) had adverse effects on the majority of their cases. Further investigation is needed to track the evolution of managed care arrangements over time, to determine whether different segments of the provider population have systematically different experiences under managed care, and to evaluate the impact of managed care on the availability and quality of substance abuse treatment services.

Table 11. Influence of Managed Care on Program Operations

Survey Question	Nearly Always	For Some Patients	Not Usually/ Rarely
Does managed care create additional barriers to treatment for special populations?	23.8	63.4	12.7
Does managed care authorize treatment of sufficient type/duration/quality to produce acceptable outcomes?	11.3	53.2	35.4
Are gatekeepers adequately trained?	10.2	46.1	43.6
Does the definition of medical necessity systematically deny care to certain categories of patients?	15.9	69.8	14.3
Does lack of uniform assessment/placement criteria result in inconsistent or unobjective referrals?	11.7	61.7	26.7
Under managed care, are adequate services being provided to special populations?	14.3	42.9	42.9
Under managed care, are substance abuse services adequately coordinated with the wraparound services needed by patients?	10.7	14.3	75.0

Source: Assessment of Maine's Substance Abuse Treatment System: Structure, Capacity, and Utilization: 1999.

4. SUMMARY AND RECOMMENDATIONS

This study has provided needed information on the capacity of Maine's formal treatment system to address the substance abuse problems of individuals demanding services. Specifically, these analyses show that on any given day the state's treatment programs are operating at or near capacity across all levels of care. However, variations in clinical protocols and treatment philosophies result in different lengths of stays across modalities and programs; as a result, programs vary in the number of patients they can treat annually.

As the Maine household telephone survey findings show so clearly, the number of individuals seeking treatment (demand) is only a small proportion of the number actually in need of treatment. To the extent that education and intervention efforts are successful in helping individuals recognize substance abuse problems and the need for treatment, demand for services will continue to rise. Thus, state funds must be allocated accordingly in order to ensure that treatment system capacity can be expanded to accommodate increasing levels of demand. On any given day, demand for treatment may exceed available supply, causing potential patients to wait for needed services. The level of care required and the average length of stay for patients in the program to which a person seeks admission will determine the length of the wait. Within and across regions, more monitoring may be necessary to match potential patients with available slots to the extent possible.

Future investigations of the capacity and utilization of Maine’s substance abuse treatment system should seek to incorporate information on services offered in the private sector (including private practitioners working outside of formal healthcare delivery organizations) and in methadone maintenance programs, as well as the characteristics of individuals most likely to seek treatment from these programs. Estimates of treatment need and demand derived from household telephone surveys are likely to be biased in favor of individuals who are employed and/or have stable residences. Individuals in more stable and affluent social circumstances are more likely to seek and receive treatment in the private sector; it is, therefore, imperative to begin to understand the types of services they typically receive and whether these treatment patterns differ systematically from treatment found in the public sector. In addition, it would be important to determine the capacity of the private sector to treat patients insured by public means (Medicaid, Medicare) because, in this sense, the private sector is a source of additional treatment slots for public-pay clients. However, estimates derived from

household surveys also will tend to underestimate the need for treatment among the unemployed, homeless, and more marginalized population. These individuals are more likely to receive assistance from the state-funded treatment system. In particular, users of heroin and other opiates tend to be underrepresented in the population of household residents; much could be learned about the characteristics of these individuals and their treatment needs and referral patterns through a detailed analysis of methadone treatment program utilization in the state and in adjoining states.

Perhaps most importantly, future investigations should seek to assess the effectiveness of treatment offered in Maine's treatment system. Although it is important for resource allocation decisions to be informed by the degree of need, demand, and available capacity in various cities and planning areas, it is equally important to determine which treatment programs are most effective. Programs that have the greatest dynamic capacity (i.e., those that can serve the most patients in a given year) are not necessarily the most effective programs. Systematic data must be collected from treatment providers to determine what services are being offered, with what frequency, and to what kinds of patients; moreover, programs must collect information about patient outcomes and compare this to baseline data collected at intake in order to determine whether the patient has shown improvement in functioning that is directly attributable to the services received. It is clear that Maine's performance-based contracting system can continue to be extremely useful in helping determine provider outcome effectiveness. This type of information will allow the state to continually enhance the set of performance indicators currently collected for treatment providers and will facilitate its ongoing processes for systematically allocating resources to programs determined to be performing at or above those required standards.

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APPENDIX A

UFDS SURVEY, 1997

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

FORM APPROVED:

OMB No: 0930-0106
APPROVAL EXPIRES: 8/31/99

DRUG AND ALCOHOL SERVICES INFORMATION SYSTEM (DASIS)
UNIFORM FACILITY DATA SET (UFDS)
OCTOBER 1, 1997

This questionnaire asks about the facility listed below. Please check the accuracy of the information. Update items that are blank or inaccurate by entering the correct information in the space provided on the lower half of this page. If you are reporting data for the first time, please provide all of the information requested.

IF NO CHANGES ARE NEEDED (ALL INFORMATION IS COMPLETE AND CORRECT), MARK (X) THIS BOX → ☐

	Don't Know		Don't Know
STATE ID _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	-1 ☐	NFR ID _ _ _ _ _ _ _ _ - _ _	-1 ☐
EIN ID:** _ _ _ _ _ _ _ _ _	-1 ☐	FDA ID _ _ _ _ _ _ _ _ - _ _	-1 ☐

**The EIN ID number is your employer identification number or your federal tax identification number. Your accounting or personnel departments may have this number.

Facility Director's Name		
Facility Name		
Mailing Address		
City	State	ZIP Code

Street Name		
City	State	ZIP Code
County	Telephone No.	Ext. *(if any)*

Facility Director's Telephone No. Ext. (if any)	Facility Fax Number:	TTY/TDD Number:

P T O A *(Office Use Only)*

Why is completing this questionnaire important?

Your participation makes a difference. The UFDS survey is the ONLY source of data on ALL known substance abuse treatment and prevention programs in the nation. When substance abuse policy makers and program managers need up-to-date national information on characteristics of substance abuse programs and the numbers and types of clients served, they rely on the UFDS. UFDS data are used to formulate the Nation's annual drug control strategy and to make many other important decisions regarding substance abuse policy.

This survey is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services.

Instructions

- The reference date for UFDS is October 1, 1997.
- Use a # 2 pencil. If you wish to change an answer, please erase cleanly.
- See example below for the proper way to record a number in a box.
- Return the completed questionnaire in the envelope provided.

If you have any questions concerning this questionnaire, or if you need additional blank forms, contact:

MATHEMATICA POLICY RESEARCH, INC.
1-888-324-UFDS (8337)

Correct

1	9

Incorrect

1	19

1. On October 1, 1997 was the facility named on the cover providing substance abuse treatment, prevention, administrative, or other nontreatment services?

☐ 1 Yes → **SKIP TO Q.2**

☐ 2 No

1a. (If No) When did this facility close or stop providing substance abuse services? RECORD MONTH AND YEAR

MONTH: |__|__|

YEAR: 19 |__|__| → **SKIP TO Q.27, PAGE 10**

☐ -1 Don't Know

2. Who is the owner of this substance abuse facility?

MARK ONE ONLY

☐ 1 A Private-for-Profit Organization

☐ 2 A Private Non-Profit Organization

☐ 3 State Government

☐ 4 Local County or Community Government

☐ 5 Tribal Government

→ **SKIP TO Q.3**

☐ 6 Federal Government

2a. Which federal government agency?

MARK ONE ONLY

☐ 1 Department of Veterans Affairs

☐ 2 Department of Defense

☐ 3 Bureau of Prisons

☐ 4 Indian Health Service

☐ 5 Other (*Specify:*

_____)

3. Does this facility operate or participate in a hotline that provides substance abuse counseling and referral services?

911 is not considered a hotline

☐ 1 Yes

☐ 2 No → **SKIP TO Q.4**

3a. Please enter the hotline telephone number(s) and hours of operation. If 24 hours, check the box.

PHONE NUMBER(S):	HOURS OF OPERATION	24 HOURS
(____)-_____	_____ Weekdays	☐
	_____ Weekends	☐
(____)-_____	_____ Weekdays	☐
	_____ Weekends	☐

4. On October 1, 1997, which of the following services were provided by this facility *at this site*?

MARK ALL THAT APPLY

☐ 1 **Substance Abuse Treatment***(services that focus on initiating and maintaining an individual's recovery from substance abuse and on averting relapse, including detoxification)*

☐ 2 **Substance Abuse Prevention***(prevention activities directed at individuals not identified to be in need of treatment, such as information dissemination or education)*

☐ 3 **Other Substance Abuse Services***(such as intake, assessment, and referral)*

☐ 4 **Administrative Services***(such as billing, personnel, and scheduling)*

5. Did you check box 1 in Q.4?

☐ 1 Yes

☐ 2 No → **SKIP TO Q.27, PAGE 10**

5a. Is a drunk driving or DUI/DWI program the ONLY substance abuse service provided by this facility?

1 ☐ Yes → **SKIP TO Q.27, PAGE 10**

2 ☐ No

6. Which ONE category best describes the SETTING of this substance abuse treatment facility?

MARK ONE

- ☐ 1 General hospital, may include an outpatient substance abuse unit on site
- ☐ 2 Psychiatric hospital, may include an outpatient substance abuse unit on site
- ☐ 3 Other specialized hospital, may include an outpatient substance abuse unit on site (for example, alcoholism, maternity, children's, orthopedic)
- ☐ 4 Solo practice
- ☐ 5 Group practice
- ☐ 6 School (elementary, secondary, college/university)
- ☐ 7 Jail, prison or juvenile detention center
- ☐ 8 Other criminal justice (TASC, pretrial diversion, court referral, probation, parole, community corrections)

→ **SKIP TO Q.7**

- ☐ 9 Other setting

6a. More specifically would you describe this facility as:

MARK YES OR NO FOR EACH

YES	NO		
1 ☐	2 ☐	a.	OUTPATIENT substance abuse treatment facility
1 ☐	2 ☐	b.	Community MENTAL health center or other mental health facility that provides a variety of services
1 ☐	2 ☐	c.	Community Health Center, including Migrant Health Center, Urban Indian Program, Health Care for the Homeless Center
1 ☐	2 ☐	d.	Halfway House
1 ☐	2 ☐	e.	Therapeutic Community
1 ☐	2 ☐	f.	Other RESIDENTIAL substance abuse treatment facility
1 ☐	2 ☐	g.	Community or religious organization/agency that provides a variety of social services
1 ☐	2 ☐	h.	Other (*Specify:* _____)

7. Is this facility owned or operated by a managed care organization (for example, an HMO)?

- ☐ 1 Yes
- ☐ 2 No

8. On October 1, 1997, did this facility have letters of agreement or contracts with managed care organizations for providing substance abuse treatment services?

- ☐ 1 Yes, had formal written agreements or contracts with managed care organizations
- ☐ 2 No formal written agreements or contracts with managed care organizations → **SKIP TO Q.9**
- ☐ -1 Don't know → **SKIP TO Q.9**

8a. With how many managed care organizations did you have formal written agreements or contracts?

Number: ☐☐☐

9. On October 1, 1997 was this facility structured as a parent organization or master site with one or more affiliate sites that provide substance abuse *treatment* services?

- ☐ 1 Yes
- ☐ 2 No → **SKIP TO Q.10, PAGE 3**

9a. On October 1, 1997, how many affiliate sites did this facility have that provide substance abuse *treatment* services?

Number: ☐☐☐

10. On October 1, 1997, was this facility an affiliate of a parent organization or master site?

☐ 1 Yes

☐ 2 No → **SKIP TO Q.10b**

10a. Please provide the following information for the parent organization/master site.

Organization: _____

Contact Name: _____

Mailing Address: _____

City: _____ State: _____

ZIP: _____ Telephone Number: (____) _____ - _____

10b. The rest of this questionnaire should be answered for those services, activities, etc. provided *at this site* by the facility listed on the cover of this questionnaire. Parent organizations or master sites should not include affiliate sites in their responses. Can you respond for only the services, activities, etc. provided at this site?

☐ 1 Yes →**SKIP TO Q.11**

☐ 2 No

10c. If responding for only this site is not possible, for approximately how many sites will you be reporting in total?

MARK ONE ONLY

☐ 2 sites

☐ 3-5 sites

☐ 6-10 sites

☐ More than 10 sites

11. Waiting Lists. If a program is full, does this facility maintain a formal waiting list of people waiting for substance abuse services?

- **Formal waiting list: a record of the names, addresses, and telephone numbers of applicants eligible for admission. *The list must include the date of application and nature of follow-up contacts.***

☐ 1 Yes

☐ 2 No → **SKIP TO Q.12, PAGE 4**

11a. On October 1, 1997, how many people were on the waiting list?

Number on Waiting List: ☐,☐☐☐

12. Number of Active Clients on October 1, 1997. In each of the categories listed below, please enter the number of active clients who were receiving substance abuse treatment at this facility on October 1, 1997:

- DO NOT count codependents, parents, other relatives, friends (i.e., "collaterals"), or other nontreatment clients.

	NUMBER	IF NONE, CHECK BOX
a. **Hospital Inpatients - Detoxification** on October 1, 1997and were<u>not</u> discharged that day	,___	☐
b. **Hospital Inpatients - Rehabilitation** on October 1, 1997and were<u>not</u> discharged that day	,___	☐
c. **Residential (24-Hour Care) - Detoxification** on October 1, 1997 and were<u>not</u> discharged that day	,___	☐
d. **Residential (24-Hour Care) - Rehabilitation** on October 1, 1997 and were<u>not</u> discharged that day	,___	☐
e. **Outpatients (Less Than 24-Hour Care)** who received a substance abuse treatment service between September 1 and October 1, 1997 and were still enrolled on October 1, 1997. . .*DO NOT INCLUDE CLIENTS WHOSE ONLY SERVICE IS ATTENDING A DUI/DWI PROGRAM*	,___	☐
f. **Intensive Outpatients*** who received a substance abuse treatment service—including day treatment—between September 1 and October 1, 1997 and were still enrolled on October 1, 1997 **(Services provided to a client that last 2 hours or more per day/3 or more days a week)*	,___	☐
g. **TOTAL NUMBER OF ACTIVE CLIENTS** (add a - f)	,___ Q.12g	

12h. Are the numbers entered in the TOTAL box Q.12g actual active client counts for October 1, 1997 or your best estimate?

☐ 1 Actual count ☐ 2 Estimate

13. Approximately what percentage of the clients in the Q.12g TOTAL box were being treated on October 1, 1997 for:

a. Alcohol Abuse Only	___.00%
b. Drug Abuse Only	___.00%
c. Both Alcohol and Drug Abuse	___.00%
TOTAL CLIENTS	**100 %**

14. Did you enter a number larger than zero in either the <u>Hospital Inpatient</u> (Q.12a or Q.12b) or <u>Residential—24 Hour Care</u> (Q.12c or Q12.d) categories in Q.12?

☐ 1 Yes ☐ 2 No → **SKIP TO Q.15, PAGE 5**

14a. On October 1, 1997, how many of the beds at this facility <u>could have been used for</u>:

	NUMBER OF BEDS	
a. Hospital Inpatient Substance Abuse Treatment	,___	☐ NONE
b. Non-Hospital Residential (24-Hour) Substance Abuse Treatment	,___	☐ NONE

CHARACTERISTICS OF ACTIVE CLIENTS ON OCTOBER 1, 1997

15. Please complete the following table for the number of active clients reported in Q.12 (page 4).

- Enter the TOTAL from Q.12g into the three TOTAL boxes in Column 1 below.
- Column 1. Enter the number of active clients for each age, race, and sex category in Column 1. For each category with no clients, enter zero, "0."
- Columns 2-4. For each age, race, and sex category with a number greater than zero in Column 1 complete Columns 2-4 to show how many clients were in each of the three types of care. The SUM of each row in Columns 2, 3 and 4 MUST EQUAL the Column 1 total for that row.

Client Category	1 TOTAL	NUMBER OF ACTIVE CLIENTS BY TYPE OF CARE: 2 HOSPITAL INPATIENT From Q.12a + Q.21b	3 RESIDENTIAL (24-HOUR CARE) From Q.12c + Q.12d	4 OUTPATIENT From Q.21e + Q.12f
AGE				
Under 18 years	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
18-20	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
21-24	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
25-34	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
35-44	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
45-64	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
65 and Over	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
Don't Know	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
TOTAL NUMBER OF ACTIVE CLIENTS (from Q.12g)	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
RACE/ETHNICITY				
White, not of Hispanic Origin	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
Black, not of Hispanic Origin	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
Hispanic	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
Asian or Pacific Islander	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
American Indian/Alaskan Native	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
Other	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
Don't Know	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
TOTAL NUMBER OF ACTIVE CLIENTS (from Q.12g)	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
GENDER				
Male	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
Female	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
Don't Know	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|
TOTAL NUMBER OF ACTIVE CLIENTS (from Q.12g)	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|	|__|,|__|__|__|

15a. Are the numbers entered in Q.15 actual active client counts for October 1, 1997 or your best estimate?

- ☐ 1 Actual active client counts
- ☐ 2 Estimate

16. Does this facility dispense the opioid substitutes methadone or LAAM at this site?

☐ 1 Yes → (Make certain your FDA ID number on the cover has been recorded and is correct)
☐ 2 No → **SKIP TO Q.17**

16a. On October 1, 1997, approximately how many of the clients in the TOTAL box at Q.12g (page 4) were receiving:

	Number
a. Methadone at this site	|___|,|___|___|___|
b. LAAM at this site	|___|,|___|___|___|

17. On October 1, 1997, about how many of the clients recorded in the TOTAL box at Q.12g were:

- Provide your answers *either* as numbers *or* percentages. Your best estimate is fine. If a reasonable estimate is not possible, mark the "Unknown" box.
- For 17a and 17b, the number entered should not exceed the total number of females reported in Q.15.
- The active clients in Q.12 can be reported more than once in categories a-h below.

	Number	OR	Percentage	Unknown
a. Pregnant?	|___|,|___|___|___|		|___|___|___| .00 %	☐ -1
b. Women with dependent children?	|___|,|___|___|___|		|___|___|___| .00 %	☐ -1
c. Injection drug users at the time of admission?	|___|,|___|___|___|		|___|___|___| .00 %	☐ -1
d. Known as having an active case of tuberculosis (TB)?	|___|,|___|___|___|		|___|___|___| .00 %	☐ -1
e. HIV positive?	|___|,|___|___|___|		|___|___|___| .00 %	☐ -1
f. Clients who had previously received substance abuse treatment from you or another facility?	|___|,|___|___|___|		|___|___|___| .00 %	☐ -1
g. Covered by managed care arrangements	|___|,|___|___|___|		|___|___|___| .00 %	☐ -1
h. Criminal justice referred clients (excluding DUI/DWI)	|___|,|___|___|___|		|___|___|___| .00 %	☐ -1

18. From October 1, 1996 to September 30, 1997—or during the most recent 12-month period for which information is available— what was this facility's:

- DO NOT INCLUDE NONTREATMENT CLIENTS

	12 - MONTH ADMISSIONS
a. Total number of substance abuse treatment admissions—count every admission for the year, which includes each admission for clients readmitted for treatment or clients entering more than one type of care	|___|___|,|___|___|___|
b. Unduplicated count of substance abuse treatment clients—count every client treated during that time period—both new clients and clients already receiving treatment. HOWEVER, count each client only once, even if a client was readmitted or treated more than once during the time period. (This count should be no less than the total reported at Q.12g)	12 - MONTH CLIENTS |___|___|,|___|___|___|

19. Is the number entered in:

	Actual Count	Best Estimate
a. Q.18a an actual admissions count for the year or your best estimate?	☐ 1	☐ 2
b. Q.18b an actual unduplicated count for the year or your best estimate?	☐ 1	☐ 2

20. As of October 1, 1997, which of these services were being provided *at this substance abuse facility*?

MARK ALL THAT APPLY

Assessment Services

- ☐ 1 Comprehensive substance abuse assessment/ diagnosis
- ☐ 2 Comprehensive mental health assessment/ diagnosis *(for example, psychological/psychiatric evaluation and testing)*
- ☐ 3 Other (*Specify:* _____)

Therapy

- ☐ 4 Family counseling
- ☐ 5 Group therapy, not including relapse prevention
- ☐ 6 Individual therapy
- ☐ 7 Pharmacotherapies/prescription medication
- ☐ 8 Relapse prevention groups
- ☐ 9 Other (*Specify:* _____)

Testing (Include testing service even if specimen is sent to outside source for chemical analysis)

- ☐ 10 Blood alcohol testing (including breathalyzer)
- ☐ 11 Drug/alcohol urine screening
- ☐ 12 Hair analysis
- ☐ 13 Hepatitis testing
- ☐ 14 HIV testing
- ☐ 15 STD testing
- ☐ 16 TB screening
- ☐ 17 Other (*Specify:* _____)

Health Services

- ☐ 18 Family planning
- ☐ 19 Medical care (including physical exams)
- ☐ 20 Prenatal care
- ☐ 21 Perinatal care
- ☐ 22 TB treatment
- ☐ 23 Health education *(for example, nutrition, contagious diseases, STD other than HIV/AIDS)*
- ☐ 24 HIV/AIDS education/counseling/support
- ☐ 25 Smoking cessation
- ☐ 26 Other (*Specify:* _____)

Continuing Care

- ☐ 27 Aftercare counseling
- ☐ 28 Alumni(ae) groups
- ☐ 29 Other (*Specify:* _____)

Programs for Special Groups

- ☐ 30 Adolescents
- ☐ 31 Dually-diagnosed (mental and substance abuse disorders)
- ☐ 32 Persons with HIV/AIDS
- ☐ 33 Pregnant/Postpartum women
- ☐ 34 Other (*Specify:* _____)

Transitional Services

- ☐ 35 Assistance with obtaining Social Services (i.e., Medicaid, WIC, SSI, SSDI)
- ☐ 36 Discharge planning
- ☐ 37 Employment counseling/training
- ☐ 38 Housing assistance
- ☐ 32 Referral to other services
- ☐ 40 Other (*Specify:* _____)

Community Outreach

- ☐ 41 Drug and alcohol education
- ☐ 42 Outreach/early intervention
- ☐ 43 Media presentations (T.V., radio, brochures)
- ☐ 44 Membership in a community partnership program
- ☐ 45 Other (*Specify:* _____)

Other Services

- ☐ 46 Academic education/GED classes
- ☐ 47 Acupuncture
- ☐ 48 Case management services
- ☐ 49 Child care
- ☐ 50 Communication skills
- ☐ 51 Detoxification from substance of abuse
- ☐ 52 Domestic violence - family/partner violence services (physical, sexual and emotional abuse)
- ☐ 53 Home visits
- ☐ 54 Life skills for independent living
- ☐ 55 Outcome follow-up (post-discharge)
- ☐ 56 Parenting/family skills development
- ☐ 57 Self-help groups, including 12-step programs
- ☐ 58 Socialization/recreational services *(for example, scheduled activities such as camping, sporting events)*
- ☐ 59 Transportation assistance to treatment
- ☐ 60 Other (*Specify:* _____)

21. Using the MOST RECENT 12 - month fiscal reporting period for which data are available, what was the *substance abuse treatment revenue or funding* for this facility? Include all sources such as client payments, insurance, government funds, and donations.

- If these data are obtained from a financial report with the information recorded in thousands of dollars, please remember to add three zeroes when recording these figures.
- If substance abuse treatment revenue is summed together with other revenue, please provide your best estimate for the substance abuse treatment portion.

Total Substance Abuse Treatment Revenue or Funding: $ |__|__|__|,|__|__|__|,|__|__|__| .00

21a. What 12 - month reporting period was used to answer Q.21?

FROM: |__|__| |__|__| 19|__|__| (Month / Day / Year) THROUGH: |__|__| |__|__| 19|__|__| (Month / Day / Year)

22. How much of the *substance abuse treatment revenue or funding* reported in Q.21 was paid directly to this facility by:

- Provide your answers *either* as numbers *or* percentages.
- If you marked category "6" (Federal government) in Q.2, you should have revenues or funding to report in category "e" below.

REVENUE OR FUNDING SOURCES	DOLLAR AMOUNT	OR	ESTIMATED PERCENT
a. Client payments (self-payment, deductibles, copayments)	$ _____		_____ %
b. Private health insurance			
1. Fee-for-service (not HMO, PPO, or managed care)	$ _____		_____ %
2. HMO/PPO/Managed care payments	$ _____		_____ %
3. Private health insurance, unspecified**	$ _____		_____ %
c. Medicaid			
1. Not managed care—Title XIX, including all Federal, State, and Local matching Medicaid funds	$ _____		_____ %
2. Managed care payments—Title XIX, including all Federal, State, and Local matching Medicaid funds	$ _____		_____ %
3. Medicaid, unspecified**	$ _____		_____ %
d. Medicare	$ _____		_____ %
e. Government funds			
1. Federal (for example, VA, CHAMPUS—not including Medicare)	$ _____		_____ %
2. State—including Federal block grants or any other State-only medical assistance	$ _____		_____ %
3. Local—not including Medicaid	$ _____		_____ %
f. Other public funds, source unspecified	$ _____		_____ %
g. Other funds (such as funds from charities, donations, fund-raising events) - *(Specify Largest Source: _____)*	$ _____		_____ %
h. Unknown	$ _____		_____ %
Total	$	*	100%

** Unspecified: Only use if you are unable to distinguish between revenue from managed care and non-managed care sources DO NOT DOUBLE COUNT REVENUE.

*Should Equal Q.21 Revenue or Funding Amount

23. To answer Q.22, did you primarily use:

MARK ONE ONLY

- ☐ 1 An audited financial statement for the substance abuse treatment facility on the cover
- ☐ 2 An unaudited financial statement for the substance abuse treatment facility on the cover
- ☐ 3 The annual budget for the substance abuse treatment facility on the cover
- ☐ 4 A financial statement, budget, or records from an administrative parent
- ☐ 5 Estimates based on other records, budgets, or statements
- ☐ 6 Other estimates

24. Does the revenue or funding information reported in Q.22 include revenues or funding for a site OTHER THAN the one identified on the cover of this questionnaire?

- ☐ 1 Yes
- ☐ 2 No → **SKIP TO Q.25**

24a. Please complete a block below for each site whose revenue or funding information is included in Q.22. Make a photocopy of this page if more address blocks are needed or send your own printout.

NFR ID #_____-__ ☐ -1 Don't Know

State ID #_____ ☐ -1 Don't Know

Name _____

_____

Location Address _____

_____

_____

City _____

State _____ ZIP Code |__|__|__|__|__|

Telephone (|__|__|__|)-|__|__|__|-|__|__|__|__|

Ext. *(if any)* _____

NFR ID #_____-__ ☐ -1 Don't Know

State ID #_____ ☐ -1 Don't Know

Name _____

_____

Location Address _____

_____

_____

City _____

State _____ ZIP Code |__|__|__|__|__|

Telephone (|__|__|__|)-|__|__|__|-|__|__|__|__|

Ext. *(if any)* _____

25. Were you able to provide revenue or funding sources in Q.22 for at least 75 percent of the total reported revenue?

- ☐ 1 Yes → **SKIP TO Q.26, PAGE 10**
- ☐ 2 No

25a. Is there another organization that can provide the revenue or funding information for your facility?

- ☐ 1 Yes → **GO TO Q.25b, PAGE 10**
- ☐ 2 No →

Please explain: _____

_____

_____

_____

_____

SKIP TO Q.26, PAGE 10

APPENDIX B

CODEBOOK: TEDS PUBLIC USE DATA FILE, 1995

CODEBOOK

Treatment Episode Data Set, 1995

Customized ICPSR Public Use Datafile for use in
Maine Treatment Needs Assessment, Study 6 (Current Treatment System)
Created with options available at
http://www.icpsr.umich.edu/samhda/tedssda.html

Variables Included in Data Set

CASEID CASE IDENTIFICATION NUMBER

Type: numeric Min: NA MD Codes: none
Decimals: 0 Max: NA

Input location: 1/1-6

---

race RACE

Identifies the client's race as being White (not Hispanic), Black (not Hispanic), Hispanic, or Other (not Hispanic).

VALUE	LABEL
1	WHITE, NOT HISPANIC
2	BLACK, NOT HISPANIC
3	HISPANIC
4	OTHER, NOT HISPANIC
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/7

---

educ YEARS OF EDUCATION

Specifies the highest school grade completed by the client.

VALUE	LABEL
1	0 TO 8 YEARS
2	9 TO 11 YEARS
3	12 YEARS/GED
4	GREATER THAN 12
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/8

employ EMPLOYMENT STATUS

Designates the client's current working status.

VALUE	LABEL
1	FULL TIME
2	PART TIME
3	UNEMPLOYED
4	NOT IN LAB FORCE
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/9

---

preg PREGNANT AT ADMISSION

Specifies whether the client is pregnant at the time of admission.

VALUE	LABEL
1	YES
2	NO
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/10

---

vet VETERAN

Specifies whether or not the client is a veteran of the uniform services (includes Coast Guard and the Commissioned Corps of the Public Health Service).

VALUE	LABEL
1	YES
2	NO
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/11

livarag LIVING ARRANGEMENTS

Specifies whether the client is homeless, a dependent or is living independently.

VALUE	LABEL
1	HOMELESS
2	DEPENDENT LIV
3	INDEP LIVING
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/12

---

priminc PRIMARY SOURCE OF INCOME

Indicates the client's chief source of income.

VALUE	LABEL
1	WAGES/SALARY
2	PUBL ASSISTANCE
3	RETIR/PEN/DISABL
4	OTHER
5	NONE
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/13

detnlf DETAILED NOT IN LABOR FORCE

This field provides more specific information about those clients who are not in the labor force. This field is related to the Minimum Data Set field "Employment Status."

VALUE	LABEL
1	HOMEMAKER
2	STUDENT
3	DISABLED
4	RETIRED/INMATE/OTH
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/14

---

marstat MARITAL STATUS

Indicates the client's marital status.

VALUE	LABEL
1	NEVER MARRIED
2	NOW MARRIED
3	SEP/DIV/WIDOWED
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/15

age AGE AT ADMISSION

Client's age at admission to treatment.

VALUE	LABEL
1	AGE 14 AND UNDER
2	15-17 YEARS OLD
3	18-24 YEARS OLD
4	25-34 YEARS OLD
5	35-44 YEARS OLD
6	45-54 YEARS OLD
7	55 YEARS AND OLDER
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/16

---

gender GENDER

Specifies the client's gender.

VALUE	LABEL
1	MALE
2	FEMALE
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/17

---

agency FEDERAL AGENCY

Specifies whether the treatment provider is privately funded.

VALUE	LABEL
1	PRIVATE PROVIDER
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/18

services SERVICE SETTING

Identifies the type of treatment into which the client was admitted (e.g., detox, intensive outpatient, residential-hospital).

VALUE	LABEL
1	DETOX-HOSP I/P
2	DETOX-FREE STAND
3	REHAB/RESID-HOSP
4	REHAB/RESID-SHRT
5	REHAB/RESID-LONG
6	AMBUL-INTEN O/P
7	AMBUL-OUTPATIENT
8	AMBUL-DETOX
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/19

---

methuse METHADONE USE IN TX

Specifies methadone will be used in the client's treatment.

VALUE	LABEL
1	YES
2	NO
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/20

daywait DAYS WAITING TO ENTER TX

Indicates the number of days that elapsed from the first time the client contacted a treatment agency until he or she began to receive treatment services.

VALUE	LABEL
0	NO DAYS
1	1 TO 7 DAYS
2	8 TO 14 DAYS
3	15 TO 21 DAYS
4	22 TO 28 DAYS
5	MORE THAN 28 DAY
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/21

---

psource PRIMARY SOURCE OF REFERRAL

Identifies the source of the referral to the drug or alcohol abuse treatment provider.

VALUE	LABEL
1	INDIVIDUAL
2	A/D CARE PROVIDR
3	OTH HLTH CARE PR
4	CRIMINAL JUSTICE
5	SCHOOL/COMM/EMPL
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/22

detcrim DETAILED CRIMINAL JUSTICE

This field provides more specific information about those clients referred by the criminal justice system. This field is related to the Minimum Data Set field "Primary Source of Referral."

VALUE	LABEL
1	CRT/ADJUD/LG ENT/DIV P
2	PAROLE/PROB/PRIS
3	DUI/DWI
4	OTHER
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/23

---

noprior NUMBER PRIOR TREATMENTS

Identifies the number of previous treatments the client has received.

VALUE	LABEL
0	0 PRIOR EPISODES
1	1 PRIOR EPISODES
2	2 PRIOR EPISODES
3	3 PRIOR EPISODES
4	4 PRIOR EPISODES
5	5 OR MORE PRIOR
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/24

sub1 PRIMARY SUBSTANCE

Identifies the client's primary substance of abuse.

VALUE	LABEL
1	NONE
2	ALCOHOL
3	COCAINE
4	MARIJUANA/HASH
5	HEROIN/OTH OPIATES
6	HALLUCINOGENS
7	STIMULANTS
8	TRANQUILIZERS
9	SEDATIVE/HYPNOTICS
10	INHALANTS
11	OVER THE COUNTER
12	OTHER
99	MISSING

Type: numeric Min: NA MD Codes: 99
Decimals: 0 Max: NA

Input location: 1/25-26

---

route1 PRIMARY ROUTE/ADMINISTRATION

Identifies the usual method of administering the primary substance.

VALUE	LABEL
1	ORAL
2	SMOKING
3	INHALATION
4	INJECTION
5	OTHER
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/27

freq1 PRIMARY FREQ. OF USE

Specifies how often the client uses the primary substance.

VALUE	LABEL
0	NO PAST MONTH
1	1-3 IN PAST MTH
2	1-2 IN PAST WK
3	3-6 IN PAST WK
4	DAILY
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/28

---

frstuse1 PRIMARY AGE OF FIRST USE

Provides information on when the client first used the primary substance.

VALUE	LABEL
1	14 AND UNDER
2	15 TO 17 YEARS
3	18 TO 24 YEARS
4	25 TO 34 YEARS
5	35 TO 44 YEARS
6	45 TO 54 YEARS
7	55 YEARS AND OVER
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/29

sub2 SECONDARY SUBSTANCE

Identifies the client's secondary substance of abuse.

VALUE	LABEL
1	NONE
2	ALCOHOL
3	COCAINE
4	MARIJUANA/HASH
5	HEROIN/OTH OPIATES
6	HALLUCINOGENS
7	STIMULANTS
8	TRANQUILIZERS
9	SEDATIVE/HYPNOTICS
10	INHALANTS
11	OVER THE COUNTER
12	OTHER
99	MISSING

Type: numeric Min: NA MD Codes: 99
Decimals: 0 Max: NA

Input location: 1/30-31

---

route2 SECONDARY ROUTE/ADMINISTRATION

Identifies the usual method of administering the secondary substance.

VALUE	LABEL
1	ORAL
2	SMOKING
3	INHALATION
4	INJECTION
5	OTHER
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/32

freq2 SECONDARY FREQ. OF USE

Specifies how often the client uses the secondary substance.

VALUE	LABEL
0	NO PAST MONTH
1	1-3 IN PAST MTH
2	1-2 IN PAST WK
3	3-6 IN PAST WK
4	DAILY
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/33

---

frstuse2 SECONDARY AGE OF FIRST USE

Provides information on when the client first used the secondary substance.

VALUE	LABEL
1	14 AND UNDER
2	15 TO 17 YEARS
3	18 TO 24 YEARS
4	25 TO 34 YEARS
5	35 TO 44 YEARS
6	45 TO 54 YEARS
7	55 YEARS AND OVER
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/34

sub3 TERTIARY SUBSTANCE

Identifies the client's tertiary substance of abuse.

VALUE	LABEL
1	NONE
2	ALCOHOL
3	COCAINE
4	MARIJUANA/HASH
5	HEROIN/OTH OPIATES
6	HALLUCINOGENS
7	STIMULANTS
8	TRANQUILIZERS
9	SEDATIVE/HYPNOTICS
10	INHALANTS
11	OVER THE COUNTER
12	OTHER
99	MISSING

Type: numeric Min: NA MD Codes: 99
Decimals: 0 Max: NA

Input location: 1/35-36

---

route3 TERTIARY ROUTE/ADMINISTRATION

Identifies the primary method of administering the tertiary substance.

VALUE	LABEL
1	ORAL
2	SMOKING
3	INHALATION
4	INJECTION
5	OTHER
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/37

freq3 TERTIARY FREQ. OF USE

Specifies how often the client uses the tertiary substance.

VALUE	LABEL
0	NO PAST MONTH
1	1-3 IN PAST MTH
2	1-2 IN PAST WK
3	3-6 IN PAST WK
4	DAILY
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/38

---

frstuse3 TERTIARY AGE OF FIRST USE

Provides information on when the client first used the tertiary substance.

VALUE	LABEL
1	14 AND UNDER
2	15 TO 17 YEARS
3	18 TO 24 YEARS
4	25 TO 34 YEARS
5	35 TO 44 YEARS
6	45 TO 54 YEARS
7	55 YEARS AND OVER
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/39

dsmcrit DIAGNOSIS CODE

This is a five-digit diagnosis code taken from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. It may be either third edition revised or the fourth edition. The system will also accept codes from the International Classification of Disease (ICD 9 or ICD-9-CM). States are encouraged to use DSM.

VALUE	LABEL
-1.0	V CODE

Type: numeric Min: NA MD Codes: none
Decimals: 1 Max: 998.9

Input location: 1/40-44

---

psyprob PSYCH PROBLEMS

Indicates whether there is a psychiatric problem in addition to the alcohol or drug problem.

VALUE	LABEL
1	YES
2	NO
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/45

---

hlthins HEALTH INSURANCE

Specifies the type of insurance a client possesses, if any.

VALUE	LABEL
1	PRV,BCBS,MCARE,HMO,OTH
2	MEDICAID
3	NONE
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/46

primpay EXPECTED SOURCE OF PAYMENT

Indicates how the client is planning to pay for treatment.

VALUE	LABEL
1	SELF PAY
2	HEALTH INS/FREE
3	MEDICAID
4	OTH GOV PAY
9	MISSING

Type: numeric Min: NA MD Codes: 9
Decimals: 0 Max: NA

Input location: 1/47

APPENDIX C

OSA AGENCY LISTING AND DATA SOURCES

Maine Treatment System Study Sampling Frame, by Modality

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Androscoggin	Behavioral Health Resources, Auburn	001	✓✓	✓✓				
	Catholic Charities/Fellowship House, Lewiston	009						✓
	Catholic Charities/St. Francis House, Auburn	005					✓✓	
	Central Maine Counseling Services, Lewiston	018	✓	✓				
	Community Concepts/Supported Journey, Auburn	003		✓				
	Facing Change, Lewiston	008		✓				
	Family Intervention Counseling Services, Auburn	002		✓				
	Harbor Light Associates, Lewiston	010		✓				
	HealthReach/New Directions/ Evergreen, Livermore Falls	019		✓✓				
	HealthReach/New Directions, Leeds	007		✓✓				
	HealthReach/New Directions/ Western ME Health Ctr., Liv. Falls	020		✓✓				
	New Beginnings	011	NOT ELIGIBLE FOR STUDY					
	New Beginnings	012	NOT ELIGIBLE FOR STUDY					

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Androscoggin (con.)	New Beginnings	013	NOT ELIGIBLE FOR STUDY					
	New England Counseling Services, Auburn	004		✓				
	St. Mary's Regional Medical Center, Lewiston	014	✓✓	✓✓	✓✓	✓✓		
	St. Mary's Regional Medical Center, Lewiston	038	✓	✓	✓	✓		
	Transitions Counseling, Auburn	006		✓✓				
	Tri-County Mental Health Services, Lewiston	015	RESPONDED AS AGENCY 250					
	Twelve-Hour Club	016	NOT ELIGIBLE FOR STUDY					
	YWCA Intervention & Education Program	017	NOT ELIGIBLE FOR STUDY					
Aroostook	Aroostook Mental Health Center, Ashland	021		✓				
	Aroostook Mental Health Center, Caribou	022	NOT ELIGIBLE FOR STUDY					
	Aroostook Mental Health Center, Caribou	023	✓✓	✓✓				

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Aroostook (con.)	Aroostook Mental Health Center, Fort Kent	024	✓✓	✓				
	Aroostook Mental Health Center, Houlton	025	✓✓	✓				
	Aroostook Mental Health Center, Limestone	027	✓✓	✓		✓✓		
	Aroostook Mental Health Center, Madawaska	028	✓✓	✓✓				
	Aroostook Mental Health Center, Presque Isle	029	✓✓	✓✓				
	Aroostook Mental Health Center, Van Buren	030		✓				
	Houlton Band of Maliseets	026	NOT ELIGIBLE FOR STUDY					
Cumberland	ACCESS Team, Portland	040		✓✓				
	Arnie Hanson Center, Portland	041			✓			
	The Bridge/Ingraham, Portland	042				✓	✓✓	
	Casco Bay Substance Abuse Resource Ctr., Portland	043		✓				
	Catholic Charities Maine Counseling Svcs., Portland	044		✓				

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Cumberland (con.)	Community Counseling Center	045		✓✓				
	Crossroads for Women, Portland	039		✓		✓		
	Crossroads for Women, Windham	068		✓✓		✓✓		
	Day One/Safer Streets, Cape Elizabeth	034	NOT ELIGIBLE FOR STUDY					
	Day One for Youth & Family, Cape Elizabeth	035	NOT ELIGIBLE FOR STUDY					
	Day One for Youth and Families, Portland	046		✓				
	Day One for Youth & Families, South Portland	063		✓✓				✓✓
	Discovery House, South Portland	064		✓				
	Evodia House/Grace House, Portland	047	✓				✓✓	
	Food Addiction/Chemical Dependency Consultants, Portland	048		✓				
	Grace House, Portland	049	RESPONDED WITH AGENCY 047					
	Harbor Light Associates, Bridgton	031		✓✓				
	Homeless Health Program, City of Portland	050		✓				
	Jackson Brook Institute, South Portland	065		✓✓	✓✓			

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Cumberland (con.)	JBI Longcreek, South Portland	066	✓✓	✓✓	✓✓			
	Randall Place/Ingraham, Portland	051						✓✓
	Recovery Center at Mercy	053	RESPONDED WITH AGENCY 052					
	Recovery Center at Mercy Hospital, Portland	052	✓	✓	✓	✓		
	Sahara Club, Portland	054	NOT ELIGIBLE FOR STUDY					
	Serenity House, Portland	055	✓✓		✓✓	✓✓	✓✓	
	SW ME Clinical Assoc., Gorham	037		✓				
	Transitions Counseling, Falmouth	036	CLOSED					
	Transitions Counseling, Portland	056		✓				
	Transitions Counseling, Portland	057	RESPONDED WITH AGENCY 056					
	Transitions Counseling, Portland	058	RESPONDED WITH AGENCY 056					
	Tri-County Mental Health Services, Bridgton	032	RESPONDED AS AGENCY 250					
	U.S. Navy Drug Abuse Program, Brunswick	033	NOT ELIGIBLE FOR STUDY					
	U.S. Postal Service	059	NOT ELIGIBLE FOR STUDY					
	VA Center Chemical Dependency Recovery Program, Portland	060	NOT ELIGIBLE FOR STUDY					

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Cumberland (con.)	Wellness Health Associates, Inc., Portland	061		✓✓				
	Westbrook Community Hospital, Westbrook	067	✓✓	✓	✓	✓✓		
	The Women's Project, Portland	167	NOT ELIGIBLE FOR STUDY					
	YWCA of Greater Portland	062	NOT ELIGIBLE FOR STUDY					
Franklin	Area Substance Abuse Partnership, Rangeley	074	NOT ELIGIBLE FOR STUDY					
	Evergreen Behavioral Svcs/Mt. Blue Hlth Ctr., Farmington	070	✓✓	✓✓				
	Harbor Light Associates, Jay	072		✓✓				
	HealthReach/Community Alternatives, Rangeley	075		✓✓				
	HealthReach/New Directions/Mt. Abram, Kingfield	073		✓✓				
	HealthReach/New Direction/Mt. Blue Hlth Ctr., East Wilton	069		✓✓				
	HealthReach/New Direction/Strong Health Center, Strong	077		✓✓				
	Rangeley Health Center/HealthReach, Rangeley	076		✓✓				

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Franklin (con.)	Tri County Mental Health Services, Farmington	071	RESPONDED AS AGENCY 250					
Hancock	Acadia Family Center, Southwest Harbor	083	✓✓	✓✓				
	Mount Desert Island Hospital, Bar Harbor	078		✓	✓			
	New Dawn Associates, Inc., Ellsworth	081		✓✓				
	Open Door Recovery Program, Ellsworth	082	✓✓	✓✓				
	Outpatient Chemical Dependency Agency, Ellsworth	080	NOT ELIGIBLE FOR STUDY					
	PATH	079	NOT ELIGIBLE FOR STUDY					
Kennebec	Crisis & Counseling Centers, Augusta	085		✓				
	Gardiner Area Community Collaborative, Gardiner	093	NOT ELIGIBLE FOR STUDY					
	HealthReach Network, Belgrades Lakes	091		✓✓				
	HealthReach Network/Hearthside, Waterville	101						✓✓

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Kennebec (con.)	HealthReach/New Direction, Augusta	086		✓✓				
	HealthReach/New Direction/ Sheepscot Valley, Coopers Mills	092		✓✓				
	HealthReach/New Direction, Waterville	096						✓✓
	HealthReach/New Direction, Waterville	097	RESPONDED WITH AGENCY 096					
	HealthReach/New Direction/Lovejoy Health Center, Albion	084		✓				
	Kennebec Valley Mental Health Center, Augusta	089		✓				
	Kennebec Valley Mental Health Center, Waterville	099		✓				
	KVCAP	098	NOT ELIGIBLE FOR STUDY					
	Maine General Medical Center, Augusta	087			✓			
	Maine Gen. Med. Ctr./Seton Unit, Waterville	100	✓	✓	✓	✓		
	Maine Gen. Med. Ctr./Spruce Street Residence, Augusta	088	✓✓					✓✓
	Maine OSA/DMHMRSAS, Augusta	163	NOT ELIGIBLE FOR STUDY					
	Maine OSA/DMHMRSAS, Augusta	164	NOT ELIGIBLE FOR STUDY					

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Kennebec (con.)	Maine OSA/DMHMRSAS, Augusta	165	NOT ELIGIBLE FOR STUDY					
	Nat'l Council on Alcoholism/ME Intervention Network	166	NOT ELIGIBLE FOR STUDY					
	Tamarack Family Services, Windsor	103		✓				
	Veterans Administration Center & Hospital, Togus	095	NOT ELIGIBLE FOR STUDY					
	Wellness Health Associates, Inc., Augusta	090		✓				
	Your Choice, Inc., Hallowell	094					✓✓	
Lincoln	Alternate Choices Counseling Services, Waldoboro	112		✓				
	Community Coalition Against Substance Abuse, Whitefield	102	NOT ELIGIBLE FOR STUDY					
	Transitions Counseling, Inc., Damariscotta	111		✓✓				
Knox	Alternate Choices Counseling Services, Rockland	107		✓				
	Community School, Camden	104	NOT ELIGIBLE FOR STUDY					

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Knox (con.)	MidCoast Mental Health Center, Rockland	109		✓✓				
	MidCoast Substance Abuse Council, Camden	105		✓✓				
	New Dawn Associates, Inc., Camden	106		✓				
	Penobscot Bay/Choice Skyward, Rockland	108	✓	✓				
	Penobscot Bay Medical Center, Rockport	110	✓✓	✓	✓✓			
Oxford	Community Concepts, Inc., South Paris	119		✓				
	Gateway Recovery/Bethel Family Health Ctr., Bethel	113		✓				
	Gateway Recovery Svcs./Steve Mem. Hosp., Norway	116		✓				
	New England Counseling Services, Mexico	114		✓✓				
	Rumford Community Hospital, Rumford	117			✓			
	St. Mary's Regional Medical Center, Mexico	115		✓✓				

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Oxford (con.)	Tri County Mental Health Services, Rumford	118	RESPONDED AS AGENCY 250					
	Tri County Mental Health Services, South Paris	120	RESPONDED AS AGENCY 250					
Penobscot	Abbak Counseling Services, Bangor	123		✓				
	Acadia Hospital, Bangor	124	✓✓	✓	✓✓	✓✓		
	Alternatives Counseling Services, Bangor	125		✓✓				
	Aroostook Mental Health Center, Patten	149		✓				
	Central Maine Indian Association, Brewer	141	NOT ELIGIBLE FOR STUDY					
	Community Health and Counseling Services, Bangor	126		✓				
	Genesis One, Bangor	127		✓				
	Hope House, Inc., Bangor	128		✓✓	✓✓			✓✓
	Janus House, Bangor	129						✓✓
	JNF Counseling Associates, Bangor	140	CLOSED					
	New Dawn Associates, Inc., Bangor	130		✓✓				
	Northeast Care, Bangor	131	✓	✓				

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Penobscot (con.)	Northeast Occupational Exchange, Bangor	132	✓	✓				
	Outpatient Chemical Dependency Agency, Bangor	133		✓✓				
	Penobscot Indian Nation Substance Abuse Svcs, Old Town	146		✓✓				
	River Coalition, Old Town	147	NOT ELIGIBLE FOR STUDY					
	Riverside Community Center, Lincoln	143		✓				
	Rural Family Counseling, Inc., Bangor	134		✓				
	Rural Family Counseling, Inc., Lincoln	144		✓				
	Rural Family Counseling, Inc., Millinocket	145	RESPONDED WITH AGENCY 144					
	Rural Family Counseling, Orono	148	RESPONDED WITH AGENCY 144					
	Sign of Hope Counseling Associates, Bangor	121		✓✓				
	Straight Talk, East Holden	142	NOT ELIGIBLE FOR STUDY					
	Twenty-Four Hour Club, Bangor	135	NOT ELIGIBLE FOR STUDY					
	Veteran's Administration Program, Bangor	136	NOT ELIGIBLE FOR STUDY					

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Penobscot (con.)	Wabanaki Mental Health Association, Bangor	122		✓✓				
	Wellspring, Inc.	138	NOT ELIGIBLE FOR STUDY					
	Wellspring, Inc.	139	NOT ELIGIBLE FOR STUDY					
	Wellspring, Inc., Bangor	137		✓			✓✓	
Piscataquis	Abbak Counseling Services, Dover-Foxcroft	152		✓✓				
	ACTION, Dover-Foxcroft	150	NOT ELIGIBLE FOR STUDY					
	Mayo Regional Hospital, Dover-Foxcroft	151		✓	✓✓			
Sagadahoc	Addiction Resource Center/MidCoast Hospital, Bath	153	✓	✓				
	HealthReach/New Direction/ Richmond Hlth Ctr., Richmond	154	✓✓					
	RINOP, Richmond	155	NOT ELIGIBLE FOR STUDY					
Somerset	G.W. Associates, Hinckley	158		✓				

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Somerset (con.)	HealthReach/Bingham Health Center, Bingham	156		✓				
	HealthReach/New Direction/Madison Hlth. Ctr., Madison	159		✓✓				
	HealthReach/New Directions, Skowhegan	161		✓✓				
	HealthReach/New Direction/Scott Webb, Hartland	157		✓✓				
	Sebasticook Valley Hospital/Acadia Options, Pittsfield	160		✓	✓✓			
	Youth & Family Services, Inc., Skowhegan	162		✓✓				
Waldo	Coastal Counseling/Waldo General Hospital, Belfast	169		✓				
	MidCoast Mental Health Center, Belfast	168		✓				
	Searsport Counseling Associates, Searsport	171		✓				
	West Bay Counseling Services, Belfast	170		✓✓				

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
Washington	Aroostook Mental Health Center, Danforth	173		✓				
	Calais Regional Hospital, Calais	172		✓✓				
	Down East Healthcare Foundation, Cornerstone	176		✓✓				
	Eastport Health Center, Eastport	174		✓				
	Indian Township Health Center, Princeton	179		✓✓				
	Kilun Kikun Transition House, Perry	177	NOT ELIGIBLE FOR STUDY					
	Regional Medical Center, Lubec	175		✓✓				
	Wolipomasu Substance Abuse Program, Perry	178		✓				
York	Counseling Center, Inc., York	191		✓✓				
	Counseling Services - Kimball Health Center, Saco	186	RESPONDED WITH AGENCY 185					
	Counseling Services, Saco	185		✓				
	Counseling Services, Inc., Sanford	190		✓				
	Dayowl Counseling, Saco	187		✓				

(continued)

Maine Treatment System Study Sampling Frame, by Modality (continued)

County	Program Name and Town	ID[1]	Outpatient		Inpatient		Other	
			Intensive	Non-Intensive	Detox	Rehab	Halfway House	Extended Residential
York (con.)	James R. Harrod Residential Treatment Center, Bar Mills	181				✓✓		
	Kittery Chemical Awareness & Prevention, Kittery	183	NOT ELIGIBLE FOR STUDY					
	Milestone Foundation, Old Orchard Beach	184						✓✓
	Sacopee Valley Health Center, Kezar Falls	182						
	STANDD-UP, Saco	188	NOT ELIGIBLE FOR STUDY					
	Transitions Counseling Inc., Saco	189		✓				
	York County Shelters, Alfred	180		✓				✓✓
	York Hospital - Family Resource Services, York	192	✓	✓	✓✓			
Statewide Locations	Tri County Mental Health (multiple locations statewide)	250		✓				

[1]ID numbers are consistent with those used by OSA on the State's Agency Listing, and are the same identifiers used in data processing.

✓=Information from ME State Needs Assessment Treatment Study
✓✓=Information from ME Alcohol and Other Drug Abuse Services, February 1997

APPENDIX D

OSA TREATMENT PROVIDER SURVEY

State of Maine

Department of Mental Health, Mental Retardation, and Substance Abuse Services

Office of Substance Abuse

Substance Abuse Treatment Provider Survey

1997

Please fill out this survey for the following service delivery unit only

NOTE: several questions in this survey ask about a "reference year"–October 1, 1996 to September 30, 1997. Accordingly, questions asking about "current practice" pertain to the end of the reference year, or very soon thereafter.

If you have any questions concerning this form, please call
Debra Brucker at the Office of Substance Abuse at 287-6415.

Section A: Program Capacity and Utilization

This section requests additional information about data provided in the UFDS survey.

A1. Please provide your best estimate of your average daily census for the year ending September 30, 1997:

a.	Hospital inpatients, detox	_____ clients
b.	Hospital inpatients, rehab	_____ clients
c.	Residential (24-hour care), detox	_____ clients
d.	Residential (24-hour care), rehab	_____ clients
e.	Outpatients (less than 24-hour care)	_____ clients
f.	Intensive Outpatients (services lasting 3 hrs or more per day, 3 or more days per week)	_____ clients
g.	Day Treatment (services lasting 5 hrs or more per day, 5 days a week)	_____ clients

A2. **On October 1, 1997, how many of the beds at this facility could have been used for:**
(write "0" if none, or circle N/A if facility has no inpatient/residential programming)

Hospital inpatient substance abuse treatment	_____ N/A
Non-hospital residential (24-hour) substance abuse treatment	_____ N/A

A3. **For the month of September 1997, how many intensive outpatient sessions were offered at this facility?**
(services lasting 2 hrs or more per day, 3 or more days per week)

_____ sessions

A3a. **How many clients are typically present in each IOP session?**
(Average number of clients attending a session)

_____ clients per session

A3b. **How many total intensive outpatient sessions does a client typically attend in the course of a treatment episode?** (Provide an estimate based on actual number of sessions typically attended, not the "recommended" number of sessions.)

_____ total IOP sessions

A4. **For the month of September 1997, how many of each type of OUTPATIENT (OP) sessions were offered at this facility?**

_____ total OP sessions
_____ group sessions
_____ individual sessions
_____ family sessions

A4a. **How many clients are typically present in each group OP session?**
(Average number of clients attending a session.)

_____ clients per group session

A4b. **How many total OP sessions does a client typically attend in the course of a treatment episode?**
(Provide an estimate based on actual number of sessions typically attended, not the "recommended" number of sessions.)

_____ total individual sessions
_____ total group sessions

A5. **For the month of September 1997, how many Day Treatment sessions were offered at this facility?** (services lasting 5 hrs or more per day, 5 days per week)

_____sessions (consider a "session" to be one day)

A5a. **How many clients are typically present in each Day Treatment session?** (Average number of clients attending a session)

_____clients per session

A5b. **How many total Day Treatment sessions does a client typically attend in the course of a treatment episode?** (Provide an estimate based on actual number of sessions typically attended, not the "recommended" number of sessions.)

_____total Day Treatment sessions

A6. **How many FTE counselors were involved in providing the total number of outpatient, intensive outpatient, and Day Treatment sessions (A3+A4+A5) offered at this facility in September 1997?**

_____FTE counselors

A7. **For the year ending September 30, 1997, what was the typical length of stay for patients in...**

a. Hospital inpatient, detox _____days
b. Hospital inpatient, rehab _____days
c. Residential care, detox _____days
d. Residential care, rehab _____days

A8. **For the year ending September 30, 1997 (or during the most recent 12-month period for which information is available), what was this facility's:**

A8a. **Total number of substance abuse treatment admissions.** (Count every admission for the year, which includes each admission for clients readmitted for treatment or entering more than one type of care at this service delivery unit.)

_____ Admissions

A8b. **Is the number provided in A8a an actual admissions count for the year or your best estimate?**

❑ actual count
❑ best estimate

A8c. **Unduplicated count of substance abuse treatment clients.** (Count each client only once, even if a client was readmitted or treated more than once. The unduplicated count should be at least as large as the total provided in A8a, but may be smaller.)

_____ clients

A8d. **Is the number provided in A8c an actual unduplicated client count or your best estimate?**

❑ actual count
❑ best estimate

A9. Does this service delivery unit dispense the opioid substitutes methadone and LAAM?

- ❑ yes
- ❑ no (go to Section B)

A9a. On October 1, 1997, how many clients were receiving:

_____ Methadone
_____ LAAM

A9b. Presently, how many doses of Methadone and LAAM can this program administer and monitor each day?

_____ Methadone doses
_____ LAAM doses

Section B: Service Delivery Unit Staffing

Questions in this section concern staffing patterns associated with serving clients in this service delivery unit. Personnel records provide the best basis for answering these questions. However, if these records are not available, please estimate answers based on your best knowledge.

Enter answers to questions B2a and B2b in the appropriate rows and columns of TABLE B-2: STAFFING, located below. ENTER A NUMBER OR ZERO IN EACH SPACE IN THE TABLE.

Important: The questions below refer to staff in terms of Full-Time Equivalents (FTE's). FTE means the number of hours that a full-time staff member are equal to one FTE. Use decimals to indicate partial FTE's, for example, one full and one half-time staff member would be considered 1.5 FTE's.

B2a. **How many Full-Time Equivalent (FTE) staff in each staffing category were employed by the service delivery unit or its parent organization during the reference year? Include full-time, part-time, and dedicated time of employees shared with other service delivery units in column B2a.**

B2b. **How many FTE staff in each staffing category currently provided regular services for this service delivery unit during the reference year but were not employees that is, worked for this service delivery unit on a contract or fee basis, as consultants, on detail or assignment from another agency? Enter number in column B2b.**

TABLE B-2: STAFFING

Staff Categories	B2a. Reference Year FTEs	B2b. Reference Year Contract/ Other Staff
(1) Psychiatrists		
(2) Other MDs		
(3) RNs/LPNs		
(4) Other medical personnel		
(5)Psychologists (MA or PhD)		
(6) Therapists (LCSW/LCPC)		
(7) Counselors (LADC)		
(8) Non-degreed counselors (RADC)		
(9) Clerical/ administrative		
(10) All other		

B3. **What percent of your total staff would you estimate are in recovery?**

_____%

B4. **What is the total percentage of clinical staff time devoted to OUTREACH functions?** (Outreach functions are defined as activities which reach into a community for the purpose of identifying persons in need of services, alerting persons and their families to the availability and location of services, and enabling persons to enter the service delivery system. Examplesinclude education, media presentations, membership in a community partnership program, etc.)

_____%

B4a. Considering all clinical staff time devoted to outreach activities, please estimate the percentages of staff time spent in each of the following OUTREACH settings. (Percentages should total 100%, where 100% represents the total amount of time given in B4.)

PERCENT TIME	OUTREACH SETTINGS
(1) _____	Schools
(2) _____	Streets
(3) _____	Housing projects
(4) _____	Other social service agencies
(5) _____	Health agencies
(6) _____	Employers
(7) _____	Families
(8) _____	Other

TOTAL = **100%** of outreach effort

B5. From October 1, 1996 through September 30, 1997, what percent of this facility's total REFERRALS were received from each of the following sources? (If exact figures are not available,please provide your best estimates.)

	PERCENT
(1) Self-referrals	_____
(2) Other units in organization	_____
(3) Client s family	_____
(4) Physicians	_____
(5) Mental health center	_____
(6) Employee assistance programs	_____
(7) Hospital	_____
(8) School	_____
(9) Employers	_____
(10) Courts/probation	_____
(11) Parole	_____
(12) Central intake	_____
(13) Driver Education and Evaluation Program	_____
(14) A.A./N.A	_____
(15) Other	_____
TOTAL	**100%**

Section C Client Intake

C1. Does this facility have any clerical or clinical staff who are solely dedicated to performing intake services (collection of basic demographic information and admission paperwork, NOT ASSESSMENT)?

❑ YES (If YES, go to C1a.)
❑ NO (If NO, go to C1c.)

C1a. How many FTE staff were devoted to INTAKE work in the service delivery unit during the reference year? Enter a number or zero in the appropriate rows and columns in TABLE C-1: INTAKE STAFFING.

C1b. How many contract FTE staff were devoted to INTAKE work in the service delivery unit during the reference year? Enter a number or zero in the appropriate rows and columns in TABLE C-1: INTAKE STAFFING.

TABLE C-1: INTAKE STAFFING

Staff Categories	C1a. Reference Year FTEs	C1b. Reference Year Contract/ Other Staff
(1) Clinical		
(2) Clerical		
(3) Medical		

C1c. If your service delivery unit does not have dedicated intake staff, what other types of staff spend part of their time involved in intake work? (Circle all that apply.)

1 Clinical
2 Clerical
3 Medical

C2. Enter answers to each of the following questions about assessment services in the appropriate row and column of TABLE C-2: ASSESSMENT SERVICES, located below.

C2a. Is this assessment service or procedure provided on site?

CIRCLE 1 IF YES CIRCLE 2 IF NO

C2b. Is this assessment service or procedure provided off site?

CIRCLE 1 IF YES CIRCLE 2 IF NO

C2c. For what percent of assessments was each procedure performed in the reference year (October 1, 1996 to September 30, 1997)?

TABLE C-2: ASSESSMENT SERVICES

Assessment Services	C2a. Procedure Done On Site Yes	C2a. Procedure Done On Site No	C2b. Procedure Done Off Site Yes	C2b. Procedure Done Off Site No	C2c. How Often Done %
(1) Psychosocial Assessment	1	2	1	2	
(2) Financial Assessment	1	2	1	2	
(3) Psychiatric Assessment by Psych RN/Tech	1	2	1	2	
(4) Psychiatric Assessment by Psychiatrist	1	2	1	2	
(5) Physical by Nurse Practitioner	1	2	1	2	
(6) Physical by MD	1	2	1	2	
(7) Urinalysis	1	2	1	2	
(8) HIV/AIDS test	1	2	1	2	
(9) TB test	1	2	1	2	
(10) Other lab work	1	2	1	2	

C3. If HIV/AIDS risk assessments are performed, how are they conducted?

1 _____ Verbal assessment
2 _____ Written questionnaire
3 _____ Not conducted

C4. What percentage of clinical staff time is devoted to case management functions?

_____%

C4a. Considering all staff time devoted to case management, please estimate in percentages the relative extent of staff time being devoted to the following case management activities. (Percentages should total 100%, where 100% reflects the total amount of case management time as given in C4)

PERCENT TIME	CLIENT NEED
(1) _____	Housing
(2) _____	Legal
(3) _____	Educational
(4) _____	Medical services
(5) _____	Income support/benefits
(6) _____	Employment
(7) _____	Family services
(8) _____	Discharge and aftercare planning
(9) _____	Tracking/monitoring/reporting
(10) _____	Referrals
(11) _____	Other
100%	TOTAL

Section D: Treatment Approach

D1. What degree of emphasis does this service delivery unit place on each type of counseling and therapy listed in TABLE D-1: THERAPEUTIC EMPHASIS? (Circle 1 if no emphasis, circle 2 if some emphasis, circle 3 if moderate emphasis, circle 4 if great emphasis.)

TABLE D-1: THERAPEUTIC EMPHASIS

Type of Counseling or Therapy	Emphasis None	Some	Moderate	Great
(1) Supportive group therapy	1	2	3	4
(2) Confrontational group therapy	1	2	3	4
(3) Task-oriented & problem-solving group therapy	1	2	3	4
(4) Family therapy	1	2	3	4
(5) 12 steps	1	2	3	4
(6) Supportive individual counseling	1	2	3	4
(7) Individual psychotherapy	1	2	3	4
(8) Individual behavioral therapy	1	2	3	4
(9) Social learning (life skills, problem solving)	1	2	3	4
(10) Medical/psychiatric model	1	2	3	4
(11) Biofeedback	1	2	3	4
(12) Spiritual	1	2	3	4
(13) Other (specify)	1	2	3	4

D2. How frequently are clients typically scheduled to receive group counseling or group therapy sessions?

1. Never / Not applicable
2. Once per month or less
3. 2-3 times per month
4. Once per week
5. Several times a week
6. Every day

D2a. What is the average length of time for each group session?

1. One hour or less
2. More than 1 hour but less than 2 hour
3. Two hours or more

D3. How frequently is the typical client scheduled to receive individual counseling or individual therapy sessions?

1. Never / Not applicable
2. Once per month or less
3. 2-3 times per month
4. Once per week
5. Several times a week
6. Every day

D3a. What is the average length of time for each individual session?

1. One hour or less
2. More than one hour but less than 2 hours
3. Two hours or more

D4. How frequently is the typical client scheduled to attend educational sessions?

1. Never / Not applicable
2. Once per month or less
3. 2-3 times per month
4. Once per week
5. Several times a week
6. Every day

D4a. What is the average length of time for each educational session?

1. One hour or less
2. More than one hour but less than two hours
3. Two hours or more

D5. How frequently is the typical client scheduled to attend family sessions?

1. Never / Not applicable
2. Once per month or less
3. 2-3 times per month
4. Once per week
5. Several times a week
6. Every day

D5a. What is the average length of time for each family session?

1. One hour or less
2. More than one hour but less than two hours
3. Two hours or more

D6. In general, how often do clients attend 12-step meetings?

1 Never/not applicable
2 Once per month or less
3 2-3 times per month
4 Once per week
5 2-3 times per week
6 4-6 times per week
7 Once per day
8 More than once per day

D6a. Where do clients attend 12-step meetings?

1 At this service delivery unit
2 Off-site
3 Both on-site and off-site

D7. Do individuals in recovery provide volunteer services in this service delivery unit?

❑ YES
❑ NO (Go to D8)

D7a. In what ways are recovering clients involved? (CIRCLE ALL THAT APPLY.)

1 Individual peer counseling
2 Leading group discussions
3 Giving lectures or one-time presentations
4 Providing outreach services
5 Transportation
6 Other

D8. *The following questions refer to treatment goals listed in TABLE D-8: TREATMENT GOALS, located below.*

D8a. **To what extent does this service delivery unit emphasize each potential goal of treatment?(Circle 1 if no emphasis, circle 2 if some emphasis, circle 3 if moderate emphasis, circle 4 if great emphasis.)**

D8b. **Please assign a rank order, from 1 to 5, expressing the value that this service delivery unit places on the 5 most important of these treatment goals. (Rank the most important as 1 and the fifth most important as 5. Assign only one rank per goal.)**

TABLE D-8: TREATMENT GOALS

Goals for Clients in Treatment	D8a. Emphasis No	Some	Mod	Great	D8b. Rank of Top 5 Goals
(1) Change of environment	1	2	3	4	
(2) Improved physical health	1	2	3	4	
(3) Better life skills, problem solving, coping skills	1	2	3	4	
(4) Improved social ethics	1	2	3	4	
(5) Spiritual growth	1	2	3	4	
(6) Better family relations/parenting skills	1	2	3	4	
(7) Improved job skills	1	2	3	4	
(8) Improved self-image, self-esteem, confidence	1	2	3	4	
(9) Improved self-insight, self-understanding, self- awareness	1	2	3	4	
(10) Abstinence from marijuana and alcohol	1	2	3	4	
(11) Abstinence from all other drugs	1	2	3	4	
(12) Avoiding AIDS infection	1	2	3	4	
(13) Establishing/utilizing a support system	1	2	3	4	
(14) Acknowledgment of extent of personal substance abuse problem	1	2	3	4	

D9. **Does this service delivery unit conduct drug screening on clients?**

- ❑ YES
- ❑ NO (Go to D10)

D9a. **How often are test specimens collected from a typical client?**

1. Less than once per month
2. Once a month
3. Twice a month
4. 3-5 times a month
5. More than 5 times a month

D9b. How are tests typically conducted?

1 Totally random
2 Some random, some targeted
3 Targeted

D9c. Where are tests (lab work) performed?

1 On-site
2 Off-site
3 Both

D10. For each service listed in TABLE D-10: ACCESS TO SERVICES, answer the following questions:

D10a. Is this service provided on site?

D10b. Is this service provided off site?

D10c. What percentage of clients receive this service?

D10d. How many Full Time Equivalent staff (FTE) are dedicated to providing the service? (IF NONE, ENTER 0)

TABLE D-10: ACCESS TO SERVICES

Service	D1-a. Service Done On Site		D10b. Service Done Off Site		D10c. Percent of Clients Receiving	D10d. FTF Staff Providing Service
	Yes	No	Yes	No		
(1) Child Care	1	2	1	2		
(2) Legal?Paraleag Assistance	1	2	1	2		
(3) Academic Training	1	2	1	2		
(4) Academic Training	1	2	1	2		
(5) Vocational Training	1	2	1	2		

D11. The following items refer to TABLE D-11: SPECIAL POPULATIONS, located below.

D11a. For the year ending September 30, 1997, what percent of clients in treatment fell into each special population group listed? ***(IF NONE, ENTER 0. Clients fall into more than one category - totals may exceed 100%).***

D11b. Does this facility offer a specialized program for each population? ***Circle 1 for YES, 2 for NO.***

TABLE D-11: SPECIAL POPULATIONS

Population Group	D11a. Percent of Client During Reference Year	D11b. Special Program YES	NO
(1) Dual diagnosed (psychiatric and substance abuse)	%	1	2
(2) Abused, battered	%	1	2
(3) Pregnant	%	1	2
(4) Probationers/parolees	%	1	2
(5) Women	%	1	2
(6) Adolescents	%	1	2
(7) Injection drug users	%	1	2
(8) Elderly/geriatric	%	1	2

Section E: Medical Services

E1. For each service listed in TABLE E-1: MEDICAL SERVICES, answer the following questions:

- **E1a.** Is this service provided on site?
- **E1b.** Is this service provided off site?
- **E1c.** What percentage of clients receive this service?
- **E1d.** How many Full Time Equivalent MD s are dedicated to providing this service? IF NONE, ENTER 0.
- **E1e.** How many Full Time Equivalent RN s are dedicated to providing this service? IF NONE, ENTER 0.
- **E1f.** How many other FTE health care staff are dedicated to providing this service? IF NONE, ENTER 0.

TABLE E-1: MEDICAL SERVICE

Medical Services	E1a. Service Offered On Site		E1b. Service Offered Off Site		E1c. Percent Clients Receiving	E1d. FTE MD	E1e. FTE RN	E1f. FTE Health Workers
	Yes	No	Yes	No				
(1) Primary Medical Care	1	2	1	2				
(2) Psychiatric Services	1	2	1	2				
(3) Pregnancy/Postpartum	1	2	1	2				
(4) Contraception	1	2	1	2				
(5) Pediatric	1	2	1	2				
(6) Medication monitoring	1	2	1	2				
(7) Acupuncture	1	2	1	2				

Section F: Discharge Procedures

F1. **What is this service delivery unit s formal definition or criterion for successful completion or graduation?** ***(Circle more than one if applicable.)***

1 Follows treatment plan
2 Remains for a length of time
3 Consistent attendance of follow-up meetings
4 No fixed definition
5 Changes in lifestyle
6 Other (Specify)

_____

F2. **What percentage of patients admitted to this service delivery unit during the reference period achieved the criterion/criteria for either completion or graduation noted in F1?**

Outpatient _____, Intensive outpatient _____, Day treatment _____, Inpatient _____

F3. **How are decisions made that clients have successfully completed treatment and should appropriately be discharged from the service delivery unit?** ***(Circle all that apply.)***

1 Individual counselor determines
2 Team of counselors/staff determine
3 Clinical supervisor
4 Medical director determines
5 Client concurs with staff determination
6 Other
7 Not applicable

F4. **Items F4A through F4g present actions that may cause clients to be discharged from a treatment program before their treatment is completed. For each item, please indicate the extent to which it is a common reason for discharge from this service delivery unit.**

F4a. Use of alcohol or illicit drugs?

1 Not at all common
2 To some extent
3 To a moderate extent
4 Very common

F4b. Involvement in illegal activities other than using illicit drugs?

1 Not at all common
2 To some extent
3 To a moderate extent
4 Very common

F4c. Missed counseling or therapy sessions?

1 Not at all common
2 To some extent
3 To a moderate extent
4 Very common

F4d. Violation of program rules or regulations against violence or other disruptive behavior?

1 Not at all common
2 To some extent
3 To a moderate extent
4 Very common

F4e. Missed family/group sessions?

1 Not at all common
2 To some extent
3 To a moderate extent
4 Very common

F4f. If there are other common reasons why patients are prematurely discharged from the treatment program, please specify:

_____

_____

_____

F5. How are decisions made to discharge clients from the service delivery unit prior to successful completion of treatment (i.e., for the kinds of reasons specified in F4)? (Circle all that apply.)

1 Individual counselor determines
2 Team of counselors/staff determines
3 Clinical supervisor determines
4 Physician determines
5 Client concurs with staff determination
6 Other
7 Not applicable

F6. Does this facility sponsor any kind of voluntary (no charge) alumni groups for clients after they leave the service delivery unit?

❑ YES
❑ NO

Section G: Payor Mix

G1. From October 1, 1996 to September 30, 1997, approximately what proportion of this facility's patients paid for their treatment services with each of the following mechanisms:

a. Medicaid _____%
b. Medicare _____%
c. Other public insurance _____%
d. Private / commercial insurance (including HMOs) _____%
e. Self-pay (cash) _____%
f. Charity / indigent _____%
g. Other (specify) _____%

Section H: Managed Care

H1. Does providing substance abuse services through managed care create additional barriers to accessing needed treatment, especially for hard-to reach populations (e.g. delays in obtaining referrals, having to go to multiple clinics, choosing a health plan, etc.)?

1 Yes, nearly always
2 Yes, for some proportion of clients
3 No, not generally
4 Never / only rarely
5 Unsure
6 N/A

H2. Is the treatment provided (or authorized) under managed care of sufficient duration, type, and quality to obtain acceptable client outcomes given the types of clients being served?

1 Yes, nearly always
2 Yes, for some proportion of clients
3 No, not generally
4 Never / only rarely
5 Unsure
6 N/A

H3. Are the gatekeepers under managed care adequately trained to detect/assess/refer these disorders?

1 Yes, nearly always
2 Yes, for some proportion of clients
3 No, not generally
4 Never / only rarely
5 Unsure
6 N/A

H4. Do the definitions of medical necessity used by managed care firms deny care to certaincategories of clients (e.g. court ordered)?

1 Yes, nearly always
2 Yes, for some proportion of clients
3 No, not generally
4 Never / only rarely
5 Unsure
6 N/A

H5. Do the lack of independent assessors and/or uniform assessment and placement criteria result in referral that are 1) subjective; 2) inconsistent; or 3) motivated by financial vs.clinical considerations?

1 Yes, nearly always
2 Yes, for some proportion of clients
3 No, not generally
4 Never / only rarely
5 Unsure
6 N/A

H6. Under managed care are adequate services being provided to special populations (e.g. minorities, dual or multiply disabled clients, the homeless, pregnant women, injection drug users)?

1 Yes, nearly always
2 Yes, for some proportion of clients
3 No, not generally
4 Never / only rarely
5 Unsure
6 N/A

H7. Are the substance abuse services provided under managed care adequately coordinated with the social and other supplemental or wraparound services needed by public clients?

1 Yes, nearly always
2 Yes, for some proportion of clients
3 No, not generally
4 Never / only rarely
5 Unsure
6 N/A

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY!